Annual Measurement & Evaluation Report

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Executive Summary

In early 2007, King County Executive Ron Sims, the King County Council, and community partners established the Children's Health Initiative (CHI) to identify and enroll children in the public health insurance programs for which they were eligible. When Washington State's new Cover All Kids law became effective on July 1, 2007, an estimated 9,000 children in King County became eligible for these public health insurance programs. The CHI immediately began helping families enroll their children in coverage and assisted them in establishing regular sources of medical and dental care.

The CHI is a public and private collaboration with funding from both King County and community partners dedicated to improving the health of children in King County. The initiative's cornerstone funding came from King County—a $1 million per year outreach funding commitment for 2007, 2008, and 2009. This significant allocation enabled Public Health – Seattle & King County (PHSKC) staff to leverage additional private sector matching resources totaling $3,000,300. Group Health Cooperative donated $1 million, the Washington Dental Service (WDS) committed $1 million, and other community partners added $1,000,300.

The overall Children's Health Initiative is composed of three parts: 1) county-funded access and outreach activities, 2) advocacy and alignment work and 3) privately-funded pilot projects. Through its access and outreach activities from 2007 to date, the CHI has successfully enrolled over 5,700 children in the publicly-funded health insurance programs for which they are eligible. In addition, the program has connected more than 4,500 of these children to medical homes and more than 3,000 to dental homes. A medical home is a regular source of healthcare, rather than the emergency room, and a dental home refers to a regular dentist.

In the CHI's advocacy and alignment work, CHI staff and Steering Committee members have played a role in expanding state and federal resources for low-income children's healthcare. Through its pilot projects, the CHI has established innovative behavioral health screening and treatment services for pregnant women, mothers and children, and has successfully implemented new systems to make enrollment in public health insurance programs easier for low-income families. The CHI also has expanded access to oral healthcare by enrolling over 800 families earning between 250% and 300% of the federal poverty level (FPL), increased delivery of preventive services through care coordinators.

To measure the effectiveness of the CHI, PHSKC contracted with an independent evaluator to design and implement a three year evaluation for the initiative. This evaluation, comprising both qualitative and quantitative methods, enabled the program to make

improvements throughout the course of its implementation and produced the data and analysis required for annual reporting to the King County Executive and King County Council. This report includes the evaluation results from January 2007 through June 2009 and is the third and final report to the King County Council on this three year initiative.

Program Highlights — January 2007 through June 2009

The King County Children's Health Initiative Components:

1. Access and Outreach:

Identified and enrolled more than 5,700 children in the publicly-funded health coverage for which they were eligible

Connected more than 4,500 children with medical homes and more than 3,000 children with dental homes

Enrolled and linked children in families with significant language, cultural, racial, and socioeconomic barriers to healthcare—which helps to address health disparities

Began tracking a set of long-term community health outcome measures to evaluate the impact of the CHI on families' access to healthcare and the resulting impacts on utilization, health status, and work and school days missed

2. Advocacy and Alignment

Successfully advocated with partners for expansion of publicly-funded health benefits to children whose families earn between 250% and 300% FPL

Collaborated with CHI partner WithinReach to achieve passage of state legislation authorizing the use of electronic signatures for Medicaid and Basic Health Plan enrollment

3. Pilot Projects

Online Enrollment: Provided funding and partnered with WithinReach to implement an online screening project that enabled 7,266 low-income individuals to learn that they were eligible for public health insurance

Behavioral Health: Contracted with partners at community health centers to screen 2,823 pregnant women and mothers for depression and mood disorders

KC Kids Dental: Coordinated with the Washington Dental Service to expand access to oral healthcare by enrolling 808 King County children (out of a possible universe of 1,000) whose families earned between 250% and 300% FPL—83% of these children obtained dental care following their enrollment and 739 dentists agreed to provide care for the newly-enrolled children

The CHI presents a model that has had positive impacts on multiple levels. Its program components and pilots have uncovered issues that have had an impact on policy at the state level, such as its identification of a gap in eligibility for dental coverage among children

under 250% FPL with medical insurance but without dental insurance. The CHI's successes and lessons learned about how to effectively locate, reach out to, enroll, and connect children to medical and dental homes have informed efforts to expand children's access to care statewide.

Access and Outreach

The Access and Outreach component of the CHI seeks out families in difficult-to-reach populations with significant language, cultural, racial, and socioeconomic barriers and helps them enroll in the publicly-funded healthcare coverage for which they are eligible. Following their enrollment, the program's staff help families establish a medical and dental home for their children. In addition, the staff educate parents regarding the importance of preventive care and teach them how to use the healthcare system. The Access and Outreach component also increases the delivery of preventive services at six safety net clinics where it employs care coordinators.

The Access and Outreach component is on track to achieve its three year goal of identifying and enrolling 6,500 children in publicly-funded health coverage. Between January 2007 and June 2009, the program's outreach staff sought out potentially eligible families and helped them complete the paperwork necessary to successfully enroll their children in health coverage. As a result, more than 5,700 children in King County obtained coverage under health insurance programs such as Medicaid, the Children's Health Program (CHP), and the Children's Health Insurance Program (CHIP).

Despite intensive outreach efforts, factors such as the weakened economy and loss of Medicaid and CHIP coverage at annual renewal time continually contribute to more families losing health coverage for their children. This impacts the estimated percentage of uninsured low-income children in the county as a whole, which remained constant at about 4.5% between 2006 and 2008.

The CHI has been particularly effective in reaching a large number of low-income families and working with them to successfully complete the health coverage application process—resulting in a high percentage of the children becoming enrolled. For example, looking at data from the fourth quarter of 2008, while King County is home to approximately one-fifth (19%) of the state's low-income children, the CHI was responsible for nearly two-thirds (64%) of the state's enrollment of low-income children in health coverage. In the same period, 82% of applications submitted by the CHI were approved for coverage by the state, compared to 54% for the rest of the state (excluding King County).

In addition, the CHI outreach staff connected families to medical and dental homes for their children. Preliminary data through June 2009 show that 73% of children received medical care and 40% received dental care following their enrollment in coverage. This rate will likely

improve over time as state data from claims continue to become available. For example, interviews with CHI-enrolled families found that only 3% reported that their children had not received care, suggesting that 97% may have established a medical home.

The program's culturally appropriate health education for parents, particularly those in isolated immigrant groups, also exceeded the participation goal of 5,000 for the three year project. As of June 2009, approximately 10,300 parents had received training about the importance of preventive care, publicly funded health insurance, and how to use the healthcare system. In interviews with enrolled families at the end of 2008, about 40% reported it was "always easy" or "usually easy" to get the care, tests, or treatment that their children needed and another 42% reported it being "somewhat easy."

A process evaluation undertaken in the spring of 2009 pointed toward several factors supporting the results of the Access and Outreach component. These factors include the use of experienced staff who reflect the target population in language, culture and ethnicity; a focus on accountability for staff performance; and a concerted effort to go beyond enrollment to ensure the linkage of children to a medical and a dental home, including a regular source of care and comprehensive preventive services.

CHI managers have found that investments in robust outreach make it possible to achieve substantial gains in enrollment. They believe that while this type of one-on-one targeted outreach will always be necessary to serve the most difficult to reach populations, greater results could be achieved if federal and state systems for enrollment were streamlined and automated and linked more effectively with local systems—making it possible to use available funding more efficiently by providing one-on-one assistance only for those families with multiple barriers. Major state-wide system changes, such as express lane eligibility, self declared income and automatic renewals, are needed to simplify enrollment for most children, allowing local outreach workers to focus on the most vulnerable families and assuring linkage to medical and dental homes.

Renewal also presents a challenge for many families after they are enrolled in coverage, creating significant barriers to continuous access to care for children. The CHI found that 38% of the children it enrolled in the 4th quarter of 2008 had previously been covered by Medicaid. While the CHI's work with the children in this category is helpful in ensuring that they retain and regain their coverage, the large number of children in this category illustrates a need to improve renewal procedures to better retain children in coverage.

CHI staff created a DVD in eight different languages that presents a short video on well child visits and why baby teeth are important. The DVD is much loved, eliciting attention and laughter from the audience, and has been distributed to a number of community agencies. One agency kept the video looping in the background during a recent fair. Cities such as Portland and Boston have also requested the video.

Advocacy and Alignment

The goal of the CHI's advocacy efforts is to expand access to healthcare for low-income families and children. By working collaboratively with the Health Coalition for Children and Youth (HCCY) and other healthcare advocates, CHI staff contributed to efforts to ensure that the state's implementation of the new Cover All Kids law incorporated strategies, policies, and budget priorities to expand access to healthcare for underserved children.

In 2008 and 2009, CHI staff and community partners navigated a complex and uncertain state legislative session. The severity of the state's budget deficit put many programs on the cutting block and necessitated aggressive advocacy to avoid complete elimination of critical functions, such as access and outreach. State outreach funding will continue during fiscal year 2009 but at about half the level of the last biennium ($2.2 million, including 2:1 federal matching funds, for two years—compared to $4.4 million in state funds the previous biennium). Given the stressors on the state budget, this partial retention of funding is an accomplishment.

Federal funds provided CHI staff and other advocates with an opportunity to work collaboratively with the state to expand eligibility for children's healthcare coverage to families earning between 250% and 300% FPL. This expansion will greatly increase the number of children statewide who are eligible to receive health coverage and their ability to obtain needed medical and dental care.

Working at the federal level, CHI staff joined forces with many children's healthcare advocates from across the country to achieve passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA). The act included a critical component, identified as necessary during the CHI dental pilot, that provides dental coverage for CHIP-eligible children who receive medical coverage from sources other than CHIP.

CHI Promotoras and their families, assisting at the Apple Health kick-off event hosted by the CHI, on July 31, 2008.

Health Innovation Pilot Projects

The CHI pilot projects aim to improve the effectiveness of health services for low-income children in King County and across the state. The three pilot projects, launched in 2007, focus on streamlining access to healthcare through web-based approaches, increasing low-income families' access to preventive and primary dental care, and integrating behavioral health services into primary care settings where low-income families obtain services.

Online Enrollment Pilot Project

Currently, many low-income families face barriers to obtaining coverage through the paper application and enrollment process. WithinReach, one of the CHI's community partners, is addressing this through the Online Enrollment Pilot Project. This project helps families in King County apply for and stay enrolled in public health coverage and links them to services through WithinReach's web-based screening and application tool at: www.ParentHelp123.org.

WithinReach's user-friendly web application, ParentHelp123, screens applicants for eligibility for health coverage (Medicaid; CHIP; Basic Health) and food assistance programs (Basic Food; Women, Infants, and Children Program [WIC]). ParentHelp123 allows users to quickly and easily fill out multiple program applications. From August 2008 to June 2009, 7,266 King County residents using the screening website were found to be likely eligible for

health coverage and 5,248 were found likely eligible for Basic Food or WIC, a supplemental food assistance and health education program for low-income women, infants, and children.

Users found to be likely eligible may proceed to complete the online application process. They can choose to have their application routed by WithinReach (via e-fax) or to print out their own completed forms, sign them, and mail them to the Department of Social and Health Services (DSHS). More than 85% of families choose to have WithinReach route their applications for them. In 2009, the online enrollment pilot project worked with DSHS to address the technical and policy issues required to create a seamless electronic submission process between ParentHelp123.org and DSHS.

WithinReach is currently working to develop a professional version of ParentHelp123 (ParentHelp Pro) that application workers and other outreach staff can use with families to rapidly fill out an application for benefits. This streamlined provider interface will allow case managers, outreach workers, eligibility workers, community health clinics, community technology center staff, and others to quickly and easily assess eligibility and enroll families in needed programs.

Oral Health Pilot

The KC Kids Dental Program, developed and administered by CHI partner, Washington Dental Service, provided no-cost dental services for eligible families through 2008. The program served children in King County between 250% and 300% FPL. The program ended in December 2008 when the state was slated to launch an extension of medical and dental coverage for children up to 300% FPL. Due to challenging state budget issues, the anticipated expansion of coverage did not take place as planned on the first of the year 2009. However, by mid-February, the state announced that medical and dental coverage for children between 250% and 300% FPL would go into effect and would be retroactive to January 1, 2009.

During its one year of operation, the KC Kids Dental Program enrolled 808 children in publicly-funded coverage—more than 80% of the estimated target population of 1,000 uninsured children in this income group. Eighty-three percent of these children were able to take advantage of this coverage and obtain dental services from 739 King County dentists in the WDS's network. WDS estimated the total value of this care at $537,456. As was hoped during the program's design, the newly-covered children received a great deal of preventive care (911 preventive visits, compared to 521 restorative visits).

In addition to enrolling children in the 250% to 300% FPL target income range, the program referred families earning less than 250% FPL to the CHI Access and Outreach Program for enrollment in healthcare coverage. These referrals included a total of 977 children.

Maternal and Child Behavioral Health Pilot

As many as 13% of women experience major or minor depression during the perinatal period and estimates of the overall prevalence of depression among mothers of young children range from 12% to 50%. Depression frequently interferes with parenting practices and coping skills, with many negative effects on caregiving and nurturance. Research has shown that untreated maternal depression can have many adverse impacts on children's healthy development.

The goal of the Maternal and Child Behavioral Health Pilot is to prevent and treat depression and other common mental health disorders in low-income pregnant women, mothers, and their children. Eight safety net clinics are piloting family-centered mental health screening and treatment services to their clients.

As of the end of May 2009, a caseload of 370 health clinic clients were receiving mental health services in primary care, including 37 children and 333 pregnant women and mothers. Overall, the health clinics have reached 90% of their caseload goal. Treatment follow-up with mothers and pregnant women has been strong—75% of women on clinic caseloads had numerous follow-up activities by phone, clinic visit, or in support groups within four weeks of their enrollment. Of those mothers with sufficient data to track outcomes, 65% showed clinical improvement in depression and 59% in anxiety (as reflected in a five point or greater change on screening scales). As research shows that improved mental health for mothers often improves the well-being of their children, the CHI is hopeful that the pilot's success in interventions with mothers is having associated positive impacts on children.

During the first 11 months of the program's implementation, the participating health clinics screened 2,823 pregnant and parenting women for depression and mood disorders. During the same time period, the clinics screened 1,731 children ages 0 – 12 for developmental red flags and 77 were identified as at risk of behavioral and/or developmental issues through other screening tools.

In contrast to successes with pregnant and parenting women, few children that were identified as at risk have thus far been assessed and engaged in treatment. Among children on current clinic caseloads, only 22% have received a comprehensive mental health clinical assessment in their primary care setting. There are a number of contributing reasons for this lack of follow-up, but foremost is the lack of guidance available for primary health providers and behavioral health staff about working with children with possible mental health issues. Clinicians often refer these children out for further assessment and intervention, but there are not sufficient or reliable referral resources at community mental health agencies. To address this issue, the CHI revised the pilot design at the end of 2008 and reprogrammed

funds to support more extensive child psychiatric consultation, evaluation, and technical assistance for the clinics to increase their capacity to assess children.

Long-term Community Health Outcomes

In addition to evaluating the CHI's program components, the multi-pronged initiative has begun to investigate its impact as a whole on a broader set of measures. These measures address the aggregate effects of the CHI along with other interventions on larger-scale outcomes of interest to local, state, and national policymakers.

The results to date indicate, not surprisingly, that making headway on major community-wide health outcomes is challenging. There has been progress on some of the long-term community health outcomes, while others remain unchanged. It is important to note that while the CHI has implemented a number of interventions targeting these outcomes, other forces such as the current recession have occurred during the same time period.

Long-term community health outcome measures that have registered progress include more positive responses about parents' level of worry about meeting their children's health needs and perception of their children's health status among families connected to care through the CHI. In addition, none of the families whose children who had been enrolled through the CHI in coverage for more than one year reported missing more than four days of school or work due to their child's illness.

Long-term community health outcome measures that have been slower to register change include uninsured rates for children. However, the uninsured rate for King County children may be affected by the current recession and has remained stable in comparison to the uninsured rate for adults which rose by 2.5 percentage points in King County from 2006 to 2008.

The long-term community health outcome measures for King County show comparable results to those of similar programs in California. The California initiatives have also found that it takes time for major changes in healthcare utilization, health status, and perceptions of access among underserved families to occur.

Unfortunately, existing data systems are inadequate to confidently measure a number of the longer-term community health outcome measures, including immunization rates and preventable ER visits and hospital admissions for CHI-enrolled children. The information in these areas is compromised by difficulties with the data systems and technology for extracting the data, small sample sizes and long lag times, and inaccuracies in reporting. The challenge in measuring these outcomes suggests that improvements in data systems, such as the adoption of electronic medical records, would greatly improve the ability of children's health efforts to understand and address whether and how children and their families are

accessing care and the impacts of this care on their health. Hopefully these data systems will improve during the near future, enabling a more complete assessment of the CHI's impact on the long-term community health outcomes.

Conclusions

Since its inception in January 2007, the CHI has accomplished a great deal. With the ambitious goals set out by the King County Executive, the King County Council and their community partners, the CHI has made major gains in increasing low-income families' access to medical, dental and behavioral healthcare services for their children. Each of the CHI program areas has achieved major successes, identified significant challenges, and gained lessons learned for future program improvements.

PHSKC has effectively administered the program by directly providing access and outreach services, working collaboratively with advocacy partners, contracting with community-based agencies for implementation of the pilot programs, and engaging an independent evaluator. In addition, PHSKC has ensured that the two advisory groups for the CHI—the Health Innovation Implementation Committee and the Access and Outreach Committee—have played vital roles in the program's implementation and evaluation.

The CHI presents a national model of a successful public and private community collaboration to help families overcome barriers and obtain needed healthcare services. The public/private partnership that developed the CHI has maintained a strong commitment to expanding healthcare coverage for children and improving the healthcare system that serves them. The financial support and leadership from Group Health Cooperative, Washington Dental Service, area hospitals, other health plans, and the many additional organizations that amplified the King County Council funding made it possible for the CHI to expand its strategies and to test models and approaches to service delivery that can serve as the foundation for an improved healthcare system for children.

I was invited to a church to give a presentation about the outreach program. When I showed up, there were only men. They were *Purapecha*, from Mexico, an indigenous group who had had their land taken away from them and had been mistreated by their government. They only trusted their peers.

I talked about a number of topics, including women's health and children's preventive care. It was tense. I was a woman, and although I'm Mexican, I was not from their tribe. There was no reaction to my presentation. No response to my jokes. No questions.

I thought I had failed, however, to my surprise; the leader called me the next day and invited me to speak again. This time the audience was all female. The men had to first approve before the women could take part.

Again, I got no immediate response from the women. It took time and persistence, but I developed the relationships and the trust. I'm seen as part of the community now and they regularly call me directly. And because of this relationship, the new *Promotora* program includes two workers from this tribe. This is so important, because the language barriers are very significant for groups that only speak indigenous languages.

--CHI Community Health Worker

Background

In April 2006, King County Executive Ron Sims convened the Children's Health Access Task Force (CHATF) to address the challenges facing King County families who were unable to obtain medical and dental care for their children. Many of these families were poor, did not speak English, and were isolated within communities of new immigrants. The task force recommended the creation of the King County Children's Health Initiative, a far-reaching effort to identify and enroll eligible children in publicly-funded health coverage and to link them with regular sources of medical and dental care.

Building on the CHATF recommendations, King County Executive Ron Sims, the King County Council, and community partners established the CHI.

The initiative's cornerstone funding came from King County—a $1 million per year outreach funding commitment for 2007, 2008, and 2009. This significant allocation enabled PHSKC staff to leverage additional private sector matching resources totaling $3,000,300. Group Health Cooperative donated $1 million, the Washington Dental Service committed $1 million (which it administered directly), and other community partners added $1,000,300. The generosity of these donors brought the total CHI resources to $6,000,300 over the 2007 – 2009 time period.

In July 2007, the new Cover All Kids state law took effect and expanded children's healthcare coverage to families earning less than 250% FPL, with an additional expansion to families earning less than 300% FPL to become effective in January 2009. At the time the new law passed, PHSKC staff estimated that 9,000 of the 15,000 uninsured children in King County would become eligible for health coverage under the new law. The challenge was to identify, locate, and enroll their families in coverage.

Policy Framework

King County Motion 12507

In May 2007, the King County Council passed Motion 12507, adopting the Children's Health Initiative and expressing its intent to dedicate $1 million for outreach and linkage annually in 2007, 2008, and 2009. The motion, outlined below, describes the CHI vision and mission, program components, program goals, governance structure, and evaluation requirements.

In adopting Motion 12507, enacting the initiative, the council recognized the following important foundations for the new program:

- King County's commitment to help the public achieve optimum health, its priority to reduce health disparities across all segments of the population, and its intent to improve the health of children
- The Public Health Operational Master Plan's (PHOMP) establishment of key goals and policies for public health

- Recognition of research indicating that removal of barriers to comprehensive care is essential in improving children's health and understanding that lack of insurance is one of most important of these barriers

- Washington State's enactment of Senate Bill 5093 expanding healthcare coverage for thousands of children across the state and its commitment to provide affordable coverage options for all children by 2010

- Recognition that there are 15,000 uninsured children in King County, that approximately 9,000 of these children were eligible for coverage under the law as of July 2007, and that an additional 1,000 will be eligible as of January 2009

- Acknowledgement of the leadership the King County Executive provided in convening the CHATF and commending the task force's recommendations to establish an outreach strategy to enroll children in insurance programs and link them to a regular source of medical and dental care

- Recognition of the importance of measurement and evaluation in determining the effectiveness of the initiative

- Prioritization of public/private partnerships as an effective resource development strategy in pursuing innovative projects

- Incubation of programs at the county level to provide evidence-based models for success in advance of the state's expanded coverage

The council also established a clear vision and mission, goals, program components, and evaluation requirements for the initiative. These components provide guidance to ensure that the CHI addresses the most important challenges in increasing low-income families' access to healthcare coverage and their children's access to healthcare services.

Vision and Mission

King County's vision is for every child in King County to achieve optimal health and grow into a healthy adult. Recognizing that regular access to healthcare is necessary to achieving optimal health, the mission of the county's Children's Health Initiative is to create conditions under which children have consistent access to comprehensive, preventive-focused primary healthcare prioritizing those activities which will have the most significant impact on health or reduction in health disparities.

Goals

1) Advocacy goals:

   a) Ensure that the state fulfills its adopted goal to extend healthcare insurance coverage to all children by 2010

   b) Ensure that the state fulfills its goal to connect children to a medical home and ensure that high-quality, cost-effective care is provided

2) Outreach goals:

   a) Improve insurance access by increasing the number of insured children by identifying and enrolling eligible children in public insurance projects

   b) Improve health knowledge by training parents and staff at community agencies to identify children's health problems and encourage families to seek preventive care

   c) Improve access to healthcare by connecting children to regular sources of medical and dental care

   d) Improve health status by ensuring that children receive appropriate evidence-based preventive healthcare services

3) Health innovation pilot projects goals:

   a) Ensure that children receive appropriately integrated services for the mouth, the mind, and the body by strengthening linkages in the healthcare system

   b) Reduce barriers children face in accessing healthcare services by developing systems that ensure children receive timely coordinated preventive care

   c) Leverage current opportunities to build evidence for future state-funded efforts by demonstrating innovative approaches and measuring effectiveness with carefully designed and implemented evaluations

Evaluation Requirements

The King County Council directed that the King County Executive evaluate the CHI in order to determine its effectiveness in meeting its goals. The council directed that these evaluation efforts should include the following components:

- Semi-annual and annual measurement and evaluation reports based on the evaluation plans to report to the implementation committees and the council (including the following requirements)
- Implementation committee charters
- Updated measurement and evaluation plans for the outreach component of the CHI
- Measurement and evaluation plans for the health innovation pilot projects component
- Summary of related activities being undertaken or funded by the state
- Recommendations on changes to the CHI based on the measurement and evaluation data or changes in state activities

Public Health Operational Master Plan

Within King County Council Motion 12507, the council found that the CHI was consistent with the adopted Policy Framework for the Health of the Public and supported the development of strategies that would further the community's ability to protect, promote, and provide for children's health. The PHOMP also provided policy and operational direction to PHSKC. With its emphasis on preventive healthcare and increasing equitable access to care, the CHI addresses the following four year PHOMP goals:

- Develop the key elements of an effective, modern health promotion program to combat the most important underlying actual causes of preventable illness and death in King County
- Increase access to affordable, quality healthcare through convening and leading the development and implementation of improved community strategies to provide services

These four year goals in turn contribute to King County's long-term goal in providing healthcare, as defined in the PHOMP:

- Increase the number of healthy years lived by people in King County and eliminate health disparities through access to affordable, appropriate, and quality healthcare services

Program Overview

The CHI is a multi-faceted effort that helps children and their families overcome barriers to obtaining needed healthcare services through a set of state-of-the-art programs.

- The Access and Outreach Component assertively reaches out to identify and enroll children in public health insurance programs for which they are eligible, employs trusted messengers from the community to deliver information about the value of early prevention and insurance, links families and children to a regular source of medical and dental care, and encourages increased delivery of preventive services within safety net clinics by utilizing care coordinators.

- The Advocacy and Alignment Component works collaboratively with state and federal policymakers to ensure full implementation of the Cover All Kids law, including federal and state healthcare coverage for all low-income children and families, targeted outreach, improvement of health literacy, linkage to medical homes, receipt of preventive services, and incentive payments for provision of quality care. Working with other child and family advocates, CHI staff work for the implementation of policies and systems that improve the health of low-income families.

- The Online Enrollment Pilot Project is building a user-friendly web-based bridge for parents to easily enroll their children in public health insurance and other basic needs programs and helps them identify where to obtain services through use of WithinReach's ParentHelp123 system. The Online Enrollment Pilot Project is also developing a Super-user Site, or Professional Version, which will enable application workers and other outreach staff to use the web-based system to rapidly complete benefit applications for their clients.

- The Maternal and Child Behavioral Health Pilot offers a diverse array of integrated mental health and medical care services for children and their families. CHI partners HealthPoint, Country Doctor Community Health Services, International Community Health Services, Neighborcare Health, Sea Mar Community Health Centers, and Valley Cities Counseling and Consultation are working with PHSKC staff to implement the program in coordination with other behavioral health activities in King County.

- The KC Kids Dental Pilot Project served as a demonstration project for the expansion of dental coverage. The program worked in collaboration with CHI's Access and Outreach component to identify children between 250% and 300% FPL, link them with a participating dentist, and provide payment for services delivered. The pilot ended in December 2008.

Evaluation Methodology

As described in King County Council Motion 12507, each component of the CHI has a specific evaluation plan that guides the assessment of its progress in achieving a defined set of outcomes. CHI staff enlisted the technical expertise of an independent evaluator to assist with the development of the evaluation plans and submitted the plans to the appropriate oversight committees for review and approval (the Access and Outreach Committee for the outreach component and the Health Innovation Implementation Committee for the pilot projects and the advocacy components).

These individual evaluation plans, when integrated, create an overall measurement and evaluation framework that tracks the results for each program component and assesses the impact of the CHI as a whole. The diagram on page 14 shows how the different components' program activities, such as locating and enrolling families, contribute to the intended results of the Access and Outreach component (e.g., increased access to insurance coverage and creation of medical homes), while also contributing to the impact of the CHI as a whole (e.g., use of preventive rather than emergency care and avoided costs).

Similarly, the Online Enrollment Pilot Project's activities of developing and providing an online application process for families that will make it easier for them to apply for publicly-funded health insurance supports the achievement of the program's intended outcome of increasing access to insurance coverage. These Online Enrollment activities complement the Access and Outreach efforts in helping low-income families establish a medical home and contribute to the increased use of preventive services, decreased reliance on emergency rooms for care, and avoidance of costly care.

The CHI has also selected additional measures that will help capture the impacts of the program as a whole. These additional measures include outcomes such as work and school days missed, reductions in preventable hospitalizations, and changes in immunization rates. The full listing of additional impact measures can be found in the Long-term Community Health Outcomes section of this report.

Data for the CHI's evaluation came from a wide variety of sources over the past three years.

- The Washington State DSHS provided information on applications and enrollment in publicly-funded health insurance and enrolled children's medical and dental visits. DSHS claims data also provided the information needed to analyze the rate of well-child visits for CHI-enrolled children ages 3 – 6.

- WithinReach staff provided information on the Online Enrollment Pilot.

- PHSKC staff provided data for the evaluation of the Maternal and Child Behavioral Health Pilot, as well as the community-based clinics contracted to provide services to mothers and their children, and the larger evaluation of the effort being conducted for the Veteran's and Human Services Levy in conjunction with the University of Washington.

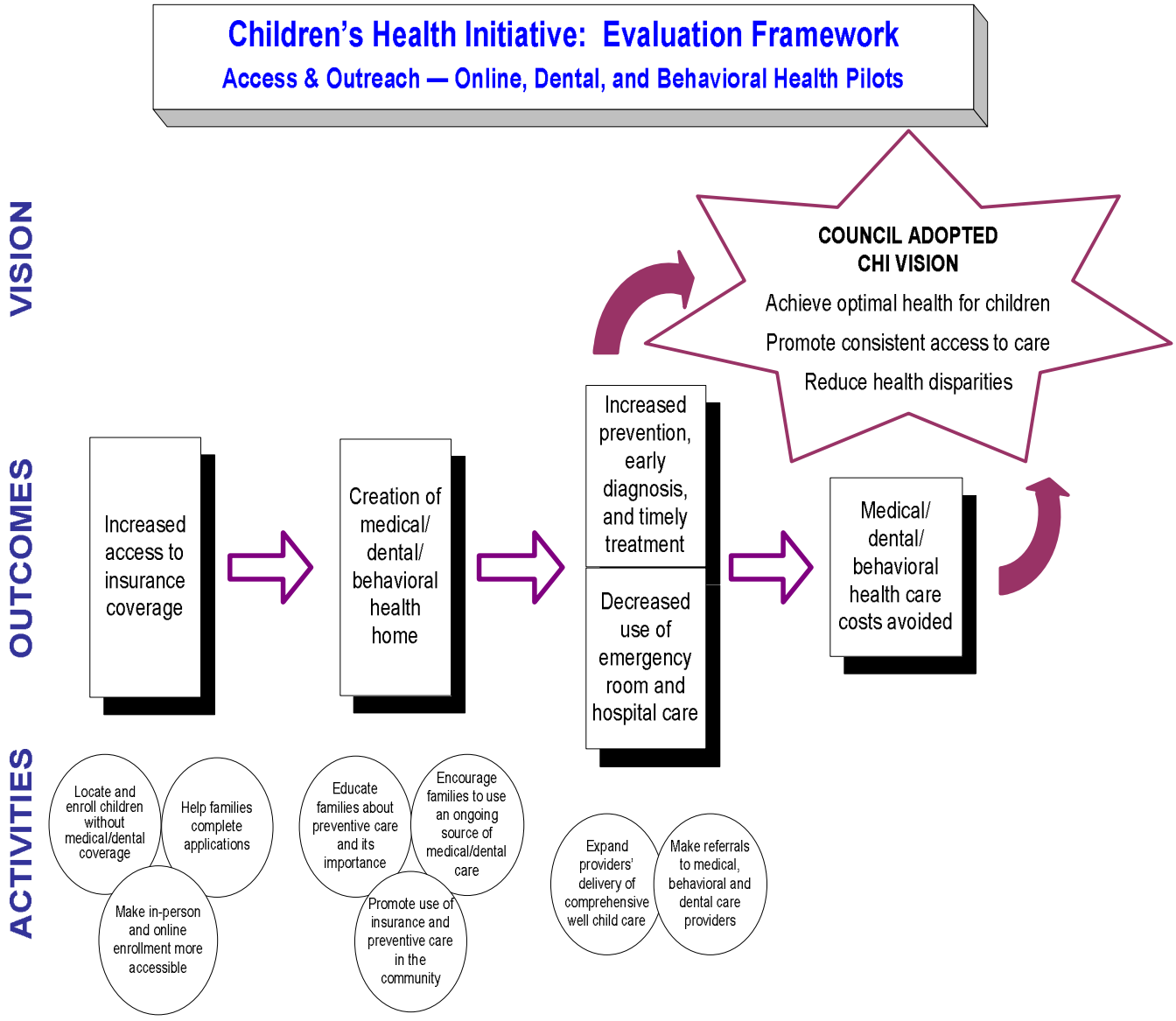
- The WDS was responsible for data collection, analysis, and reporting on the KC Kids Dental Pilot, including data from its records on enrollment and service delivery and surveys conducted in 2008 with clients and participating dentists.

- In December 2008, Gilmore Research Group conducted interviews with 153 families enrolled through the CHI. The family interview questions focused on five of the long-term community health outcome measures identified for the CHI.

- In 2009, Clegg & Associates conducted a process evaluation of the Access and Outreach component of the CHI. The process evaluation included data submitted by contracted service providers and from key informant interviews with staff and managers at PHSKC and community-based agencies in order to document the program's implementation, its service delivery model, strategies used by staff to reach, enroll and connect families and children to healthcare, and the different factors supporting and impeding the success of the effort.

PHSKC's Assessment, Policy Development and Evaluation (APDE) staff provided the analysis and summary of data from the Washington State Population Surveys from 2002, 2004, 2006, and 2008 on uninsured children and adults in King County and Washington State. APDE staff also conducted the analysis of data from the state's Department of Health to provide information on immunization rates for children ages 27 – 36 months.

In addition to these data sources, PHSKC's CHI staff met periodically with Clegg & Associates throughout the evaluation process to discuss the data available and data collection issues, findings from analyses, and lessons learned during the implementation of the CHI.


Children's Health Initiative: Evaluation Framework
Access & Outreach — Online, Dental, and Behavioral Health Pilots
VISION
COUNCIL ADOPTED CHI VISION
Achieve optimal health for children
Promote consistent access to care
Reduce health disparities
OUTCOMES
Increased access to insurance coverage
Creation of medical/ dental/ behavioral health home
Increased prevention, early diagnosis, and timely treatment
Decreased use of emergency room and hospital care
Medical/ dental/ behavioral health care costs avoided
ACTIVITIES
Locate and enroll children without medical/dental coverage
Help families complete applications
Make in-person and online enrollment more accessible
Educate families about preventive care and its importance
Encourage families to use an ongoing source of medical/dental care
Promote use of insurance and preventive care in the community
Expand providers' delivery of comprehensive well child care
Make referrals to medical, behavioral and dental care providers

Access & Outreach

Purpose

The Access and Outreach component of the CHI disseminates messages and provides education about the value of insurance coverage and early prevention. It proactively reaches out to identify eligible low-income families, enrolling them in publicly-funded health insurance programs. The CHI's outreach efforts target difficult-to-reach populations with significant language, cultural, racial, and socioeconomic barriers to address existing disparities in healthcare access. After enrollment, the CHI links the children to medical and dental homes, integrated preventive care, and needed wrap-around services, making it more likely children will receive the preventive care they need in a cost effective setting. Care coordinators in six safety net clinics, contracted through the CHI, use quality improvement techniques to expand the delivery of comprehensive preventive medical services, remove barriers to care, and help ensure children's completion of treatment.

> "Access and Outreach staff work hard to help families become covered and hang onto their coverage. Families coming in are often overwhelmed in their lives and have so much going on that they can't connect in any consistent way, needing support throughout the enrollment and linkage-to-care process."
>
> *–Public Health Department Manager*

Some examples of the breadth and depth of CHI's outreach efforts around King County include:

- Enlisting, training and supervising 24 volunteer Latino community health workers as part of the CHI's Promotora Program to provide health information, children's medical application assistance, linkage to medical and dental homes, and help with navigating systems—as trusted community members, the promotoras are able to help families that normally do not seek help
- Training social service providers, school staff, and food bank volunteers on Vashon Island about application assistance for Medicaid, Basic Food, and Basic Health in response to a growing population of low-income Latinos
- Increasing outreach with faith-based organizations in South King County, especially at church-based English literacy classes, establishing a new outreach site at the Children's Home Society Family Resource Center in Auburn, and providing training to the family advocates who make home visits to Early Head Start families
- Creating an outreach site at the English Language Learner registration office at the Highline School District to enroll children as their parents register them for school and leading a targeted outreach campaign at Mount View Elementary to ensure that all children at the school have healthcare coverage and access to a medical and dental provider—a program that will be expanded district-wide next year
- Sending an application worker to the King County Superior Court to reach parents and guardians directly and to bring the CHI program to the attention of the judges, who helped connect CHI staff with detained youth, including many homeless youth, in order to help them obtain coverage and treatment
- Outreach at the Bellevue Crossroads mall which resulted in referrals of shoppers, as well as staff's own networks of family and friends

Health educators worked with parents, caregivers, staff, and children to provide information on the availability of healthcare coverage and the importance of preventive care. They also organized African American community leaders, beginning with the faith community, to become more involved in children's health, including hosting a Black Ministers' Breakfast—designed to engage leaders in discussion on existing disparities in healthcare access and the CHI's outreach efforts targeting African American children.

"Knowledge is power. Giving families information about the importance of preventive care and opportunities to cover their children is more effective than telling them what to do."

–Community Health Educator

May 16, 2009 – Black Ministers' Breakfast: Discussing disparities in healthcare access and outreach efforts targeting African American children in King County. From left to right: Carol Allen, CHI staff; Brianna Beleford; and the Reverend Fordie Edward Ross.

In 2008, health educators focused their attention on oral health, based on data that only 40% of children with Medicaid coverage and only 12% of those under age 2 see a dentist. They worked in a number of venues and a wide variety of providers to train groups on oral healthcare for young children and worked to support the Access to Baby and Child Dentistry (ABCD) program. Their outreach about oral health included:

- Children ages 2 – 6 at preschool, ECEAP, Head Start, Early Learning Network, and Play and Learn programs
- Educators, family support workers, family child care providers, child care center providers, and other staff at community agencies
- Train the trainer sessions for high school students in the dental program at Puget Sound Skills Center

Interviews of families with children enrolled by the CHI found increases in ease of access and confidence. Families enrolling their children in coverage during 2007, who were interviewed at the end of 2008, reported greater ease in accessing needed health services for their children and had more confidence in accessing health services for their children than did families who had been enrolled in coverage for a month or less.

A process evaluation undertaken in the spring of 2009 pointed to several factors influencing the success of Access and Outreach, including experienced staff who represent the target population, a concerted effort to go beyond enrollment to ensure the linkage of children to a regular source of care and comprehensive

preventive services, and a focus on accountability for performance. The CHI models successful strategies for addressing existing disparities in healthcare access by using staff, contractors, and volunteers who share the language, culture, and background of the clients targeted by the program. This creates trust—which encourages enrollment and linkage to healthcare providers.

Results

The Access and Outreach team met and exceeded all of its objectives for 2008 and is on track to meet the targets set for 2009. The table below summarizes the program's progress to date.

2007–2009 Objectives	Key Measures	Outcomes						
		2007 Results	2008 Results	% of 2008 Objective Accomplished	2009 Results to Date (through June 2009)	Total Objective 2007–2009	Total Results to Date	% of Total Objective Accomplished to Date**
Enroll **6,500** children in public insurance programs (Medicaid, CHIP, BHP, and Children's Health Program)	Accepted applications and renewals for Medicaid, CHIP and CHP, for children under 19	1,420	3,043	117%	1,322	6,500	5,785	89%
Increase by **5,000** the number of community agency trained regarding recommended preventive care, health insurance, and linkage to medical and dental homes	Number of staff trained	2,783	3,528	176%	899	5,000	7,210	144%

2007–2010 Objectives	Key Measures	Outcomes						
		2007 Results	2008 Results	% of 2008 Objective Accomplished	2009 Results to Date (through June 2009)	Total Objective 2007–2009	Total Results to Date	% of Total Objective Accomplished to Date**
Provide **5,000** parents of low-income children especially in isolated immigrant groups with culturally appropriate health education and guidance regarding recommended preventive care, health insurance, and linkage to medical and dental homes	Number of parents or caregivers trained	4,831	3,764	251%	1,725	5,000	10,320	206%
Provide **2,700** low-income children especially in isolated immigrant groups with culturally appropriate health education and guidance regarding oral health, and general preventive care for teens	Number of children receiving preventive health education	N/A (not originally identified as an objective)	2,794	233%	2,485	2,700 (for 2008–2009)	5,279	N/A

2007–2010 Objectives	Key Measures	Outcomes						
		2007 Results	2008 Results	% of 2008 Objective Accomplished	2009 Results to Date (through June 2009)	Total Objective 2007–2009	Total Results to Date	% of Total Objective Accomplished to Date**
Decrease persistent cultural barriers for 300 families in isolated immigrant groups re: insurance, access, or health system navigation issues	Number of families assisted	104	189	189%	249	300	542	181%
Establish medical homes for 4,500 children	Number of children completing ≥ 1 medical visit	82%	Available data through 2008 showed 73% of children enrolled had established a medical home and 40% had established a dental home This is preliminary data given the lag in claims reporting		Complete data on medical and dental homes will not be available for 2009 clients until 2010	4,500	Not available until 2010, due to lag time for claims data	
Establish dental homes for 3,000 children	Number of children completing ≥ 1 oral health visit	49%				3,000		

2007–2010 Objectives	Key Measures	Outcomes						
		2007 Results	2008 Results	% of 2008 Objective Accomplished	2009 Results to Date (through June 2009)	Total Objective 2007–2009	Total Results to Date	% of Total Objective Accomplished to Date**
Increase the percentage of 3–6 year old children who are up-to-date on EPSDT visits*	HEDIS measures for 3–6 year olds*		Data from clinics reporting on this improvement area show an increase of 4% and a decrease of 13%			N/A	3 year data on these measures will be available in 2010	
Increase the number of children with a oral health visit by age 1 by X*	Number of children receiving oral health check by dentist or physician by 18 months*		Data from clinics reporting on this improvement area show increases from contract start to Dec 2008 of 42%, 49%, 114%, and 257%			N/A		

2007–2010 Objectives	Key Measures	Outcomes						
		2007 Results	2008 Results	% of 2008 Objective Accomplished	2009 Results to Date (through June 2009)	Total Objective 2007–2009	Total Results to Date	% of Total Objective Accomplished to Date**
Increase the number of fluoride applications for children by X*	Number of fluoride varnishes and/or % of children with EPSDT receiving fluoride varnish*		Data from clinics reporting on this improvement area show increases of 17%, and 104% for 0–5 and 79% for 6–10			N/A	Data on these measures will not be available because information reported by clinics is for all children served by the clinics, rather than all CHI-enrolled children	
Increase the number of children with immunizations up-to-date by X%*	HEDIS measures for 19–35 months*		Data from clinics reporting on this improvement area show increases of 6%, 22%, 63%, and 79%			N/A		
Increase the number of children 0–5 who receive a structured developmental assessment by X%*	% of 0–6 yr olds with EPSDT receiving validated screening*		Data from the clinic reporting on this improvement area show an increase of 3% (from 87% to 90%)			N/A		

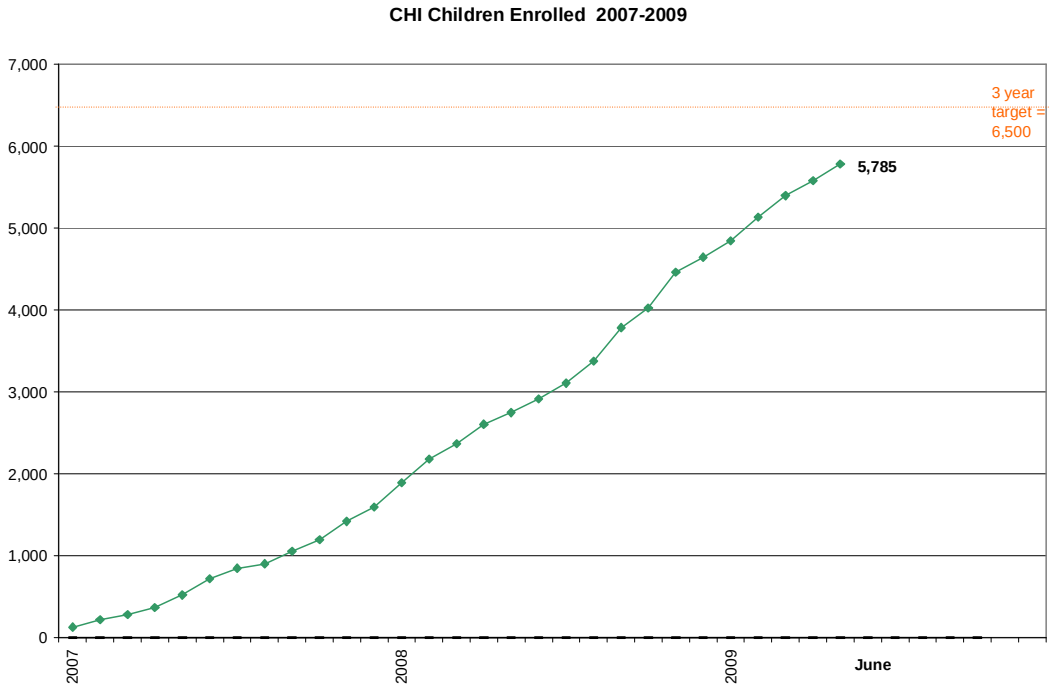
** Jan 2007 – May 2009 = 81% of the three year period

* Contracted clinics were asked to choose two of these five areas for improvement. Data on the measures reported by clinics with care coordinators are for all children at those clinics, not just CHI-enrolled children. Objectives varied in percent improvement dependent on clinic's baseline.

Enrollment

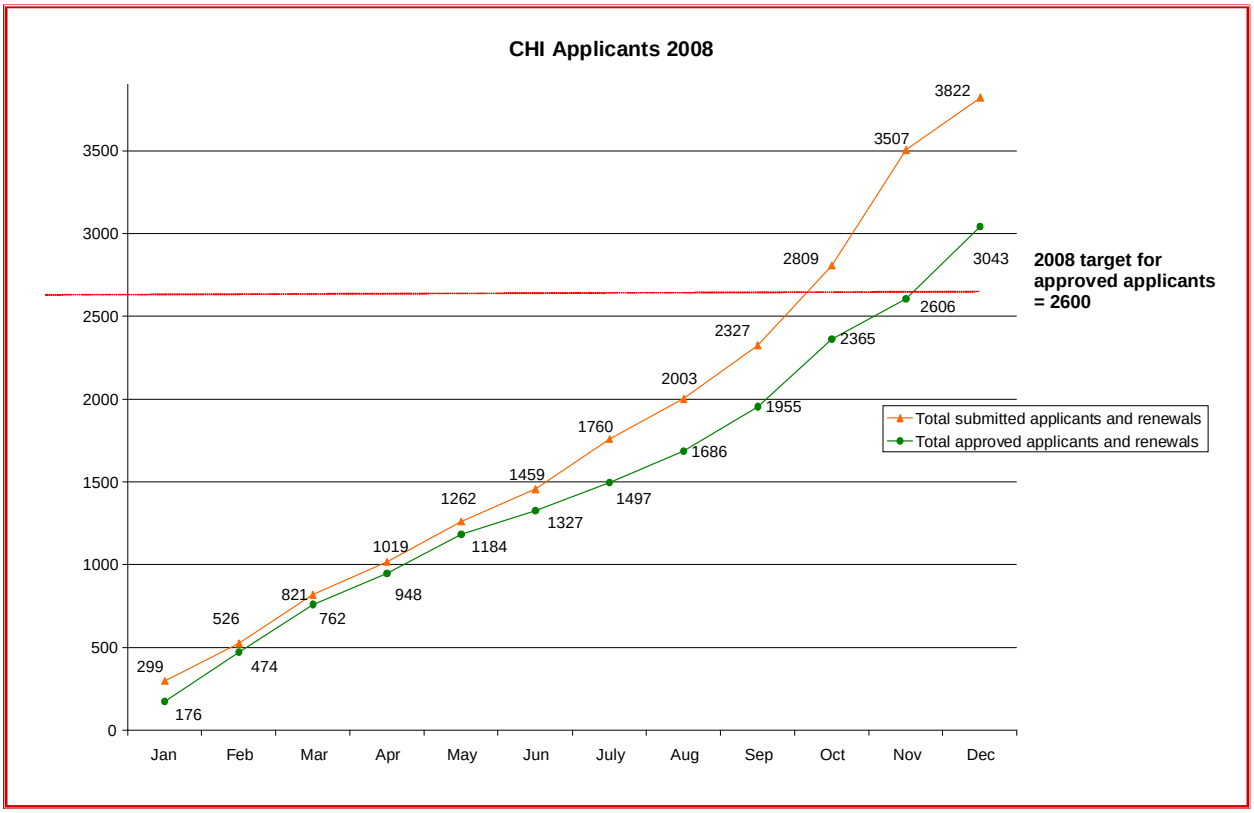
The CHI has been successful in enrolling a large number of children, accounting for a high percentage of the total number of children enrolled in the state and registering a high approval rate for CHI-submitted applications. While approximately one-fifth (19%) of low-income children reside in King County, the CHI was responsible for nearly two-thirds (64%) of enrolled children in the state. In addition, the approval rates for applications submitted by the CHI, looking at data from the fourth quarter of 2008, was 66% higher than the rest of the state, at 82% for CHI-submitted applications and 54% for Washington State excluding King County.

The CHI has enrolled 5,785 children in publicly-funded healthcare insurance since the program began in January 2007. The program is on track to meet its three year enrollment goal of 6,500 children.



Trends suggest that the fall of 2009 will be increasingly busy, similar to an active fall of 2008, due to the beginning of the school year and job losses. The CHI enrolled 906 children during the fourth quarter of 2008, which is 27% more than the average number enrolled in the first three quarters of the year. The following table and chart show CHI applicants and approvals by month.

	Jan 2009	Feb 2009	Mar 2009	Apr 2009
Submitted Applicants	289	543	787	1,002
Approved Applicants	156	321	551	815



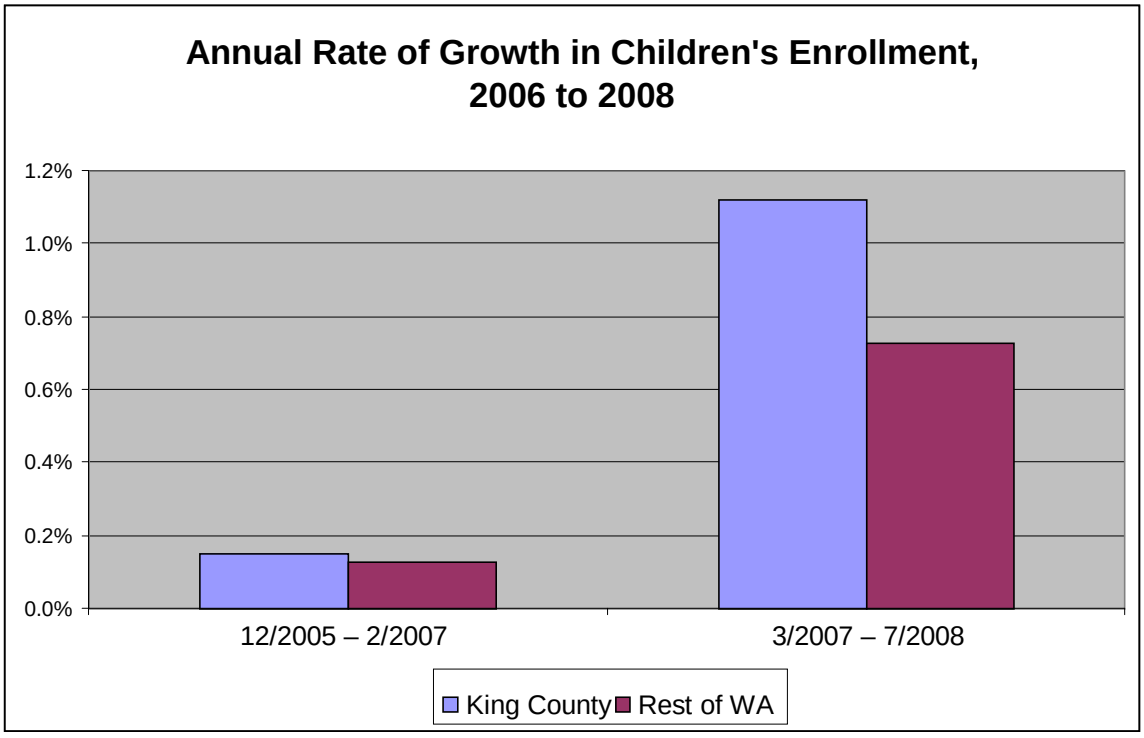
Approval rates for applications submitted by PHSKC for King County children are high. Because applications often include more than one child per family and DSHS reports on approved children rather than applications, it is impossible to report an exact approval rate for applications. However, using DSHS's estimate that an average of 1.7 children are submitted on each application and including the children that had been previously covered through Medicaid, which are counted separately from new approvals, finds that PHSKC's approval rate of 82% for the fourth quarter of 2008 is considerably higher than the balance of the state's rate of 54%. The following chart shows the available and estimated numbers.

	Submitted 4th Quarter 2008		Total Children Enrolled**	
	Submitted Applications	Submitted Children*	Number of Children Enrolled	Percentage of Children Enrolled
WA State Total	3,203	5,445	3,657	67%
CHI – King County	1,507	2,562	2,097	82%
Rest of WA State, excluding King County	1,696	2,883	1,560	54%

* The number of children submitted on applications for coverage is an estimate based on DSHS's average of 1.7 children per application.

** Total children enrolled includes both new enrollees and children who were previously enrolled in Medicaid that retain or regain coverage.

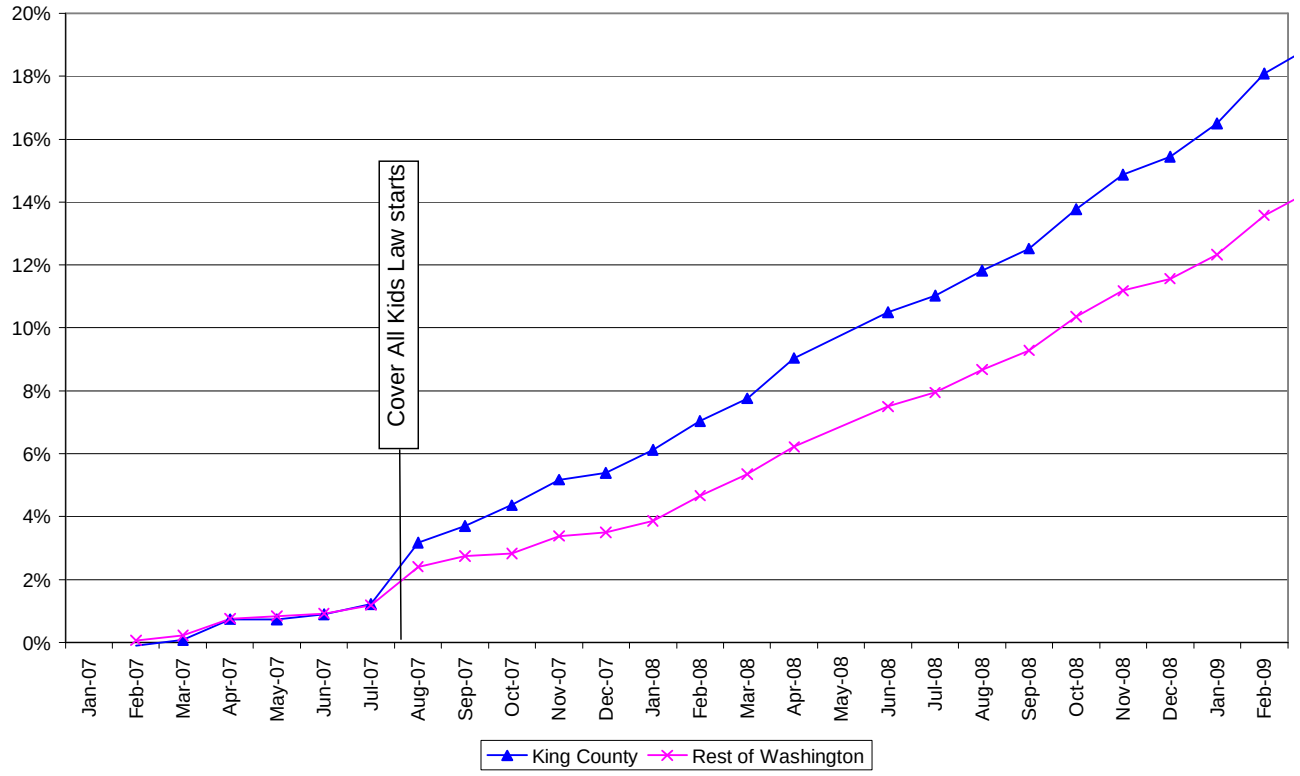
Analysis shows that King County's enrollment of children is increasing more quickly than enrollment for children in the rest of Washington. While rates for the first two months of the initiative, January and February of 2007, were similar for King County and the rest of the state, starting in March 2007 enrollment growth in King County has been considerably larger than that in the rest of the state—increasing over 1% per month for King County compared to 0.7% per month for the rest of Washington. The following chart shows the annual rate of growth in children's enrollment for King County and the rest of the state for this period.



Overall, children's enrollment in Medicaid and CHIP has grown more quickly in King County than in the rest of Washington since December 2006, one month before the CHI began. The CHI had a pilot phase from January 2007 to March 2007 and expanded to full size between April and June 2007. At fully funded status, the CHI and other King County outreach agencies were able to increase children's coverage at a substantially faster rate than the rest of the state. King County children's health coverage grew 19% (from 106,852 in January 2007 to 127,087 in February 2009) while the rest of Washington's enrollment grew by 14% (from 553,630 children in January 2007 to 633,126 in February 2009).[1] See the chart on the following page.

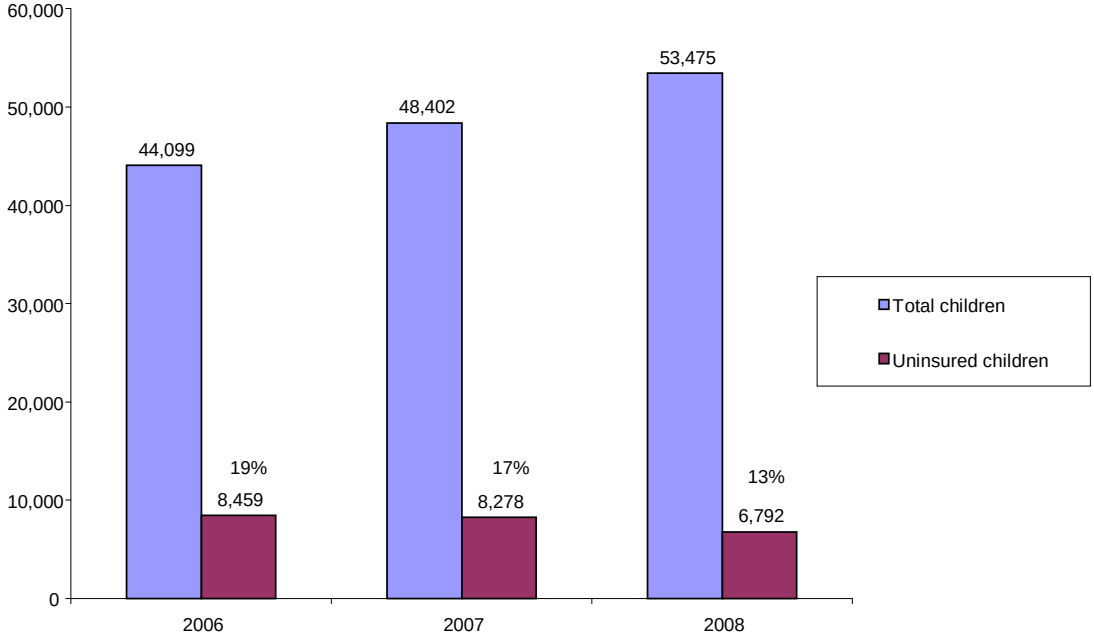
[1] Includes children ages 0 – 19 enrolled in the Children's Medical Program and Medicaid Categorically Needy (CN) Family Medicaid Program and Blind/Disabled. Also includes any enrollees in this age group that may qualify for Medicaid pregnancy coverage.

**Children's Medical Program Enrollment Growth since 1/07,
King County and the Rest of the State, 1/07 to 2/09**



Data from safety net clinics in King County shows an increase in the number of children served with healthcare coverage and an increase in the total number of children served regardless of insurance status. From 2007 to 2008, the proportion of children served by the safety net clinics who were uninsured decreased from 19% to 13%. The chart on the following page shows the increase in total children served and the decrease in the number of uninsured children.

Insurance Status of Community Health Center, Odessa Brown, HMC Clinic and Public Health Center Clients Age 18 and Under, 2006 – 2008



The decrease in uninsured children and increase in total children served are partially explained by expanded eligibility requirements, as well as CHI and clinic efforts to enroll children in coverage and link them to care. In contrast, the proportion of adults who were uninsured stayed the same (at 48%) and the number of uninsured adults served at safety net clinics remained nearly the same (with 46,913 served in 2007 and 46,206 in 2008).

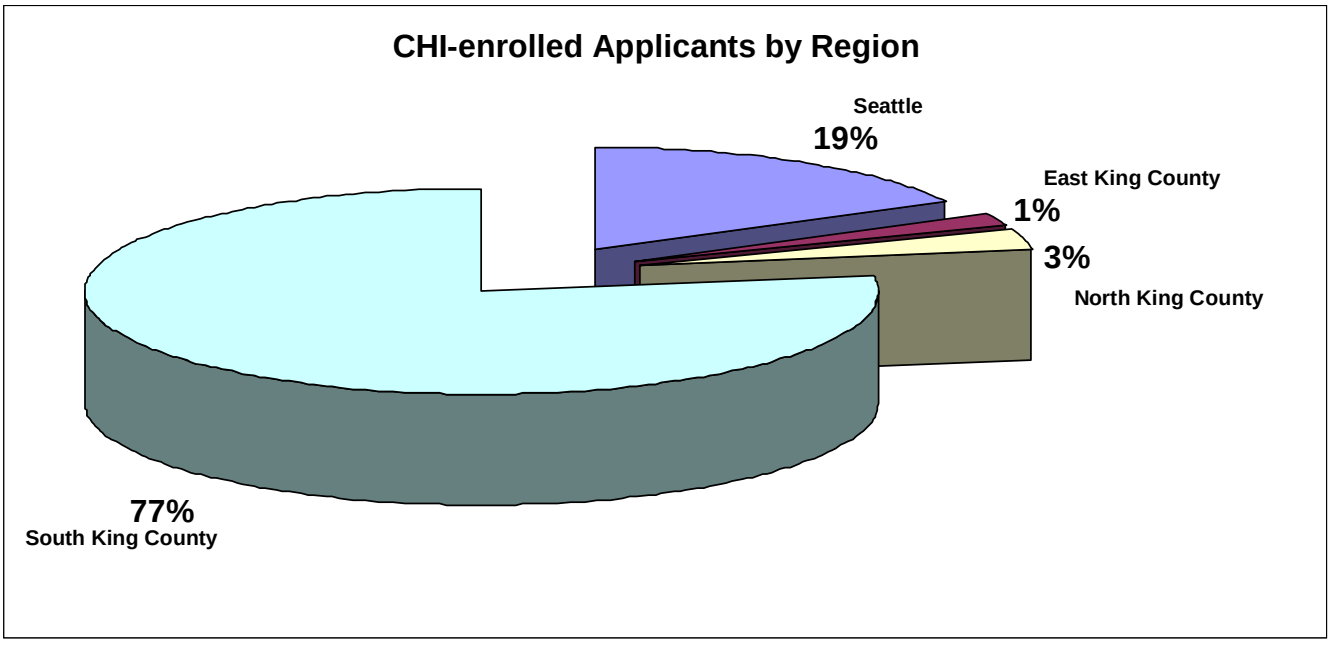
Geographic, Racial, and Ethnic Distribution of Children Enrolled through the CHI

The CHI was effective in reaching a broad range of children across racial, ethnic, and geographic lines. The table on the following page shows the distribution of children enrolled through the CHI by health planning area. The greatest number of enrolled children were living in Federal Way, followed by Kent, Burien/Des Moines, and White Center/Boulevard Park. Enrolled children, however, also lived throughout North and East King County.

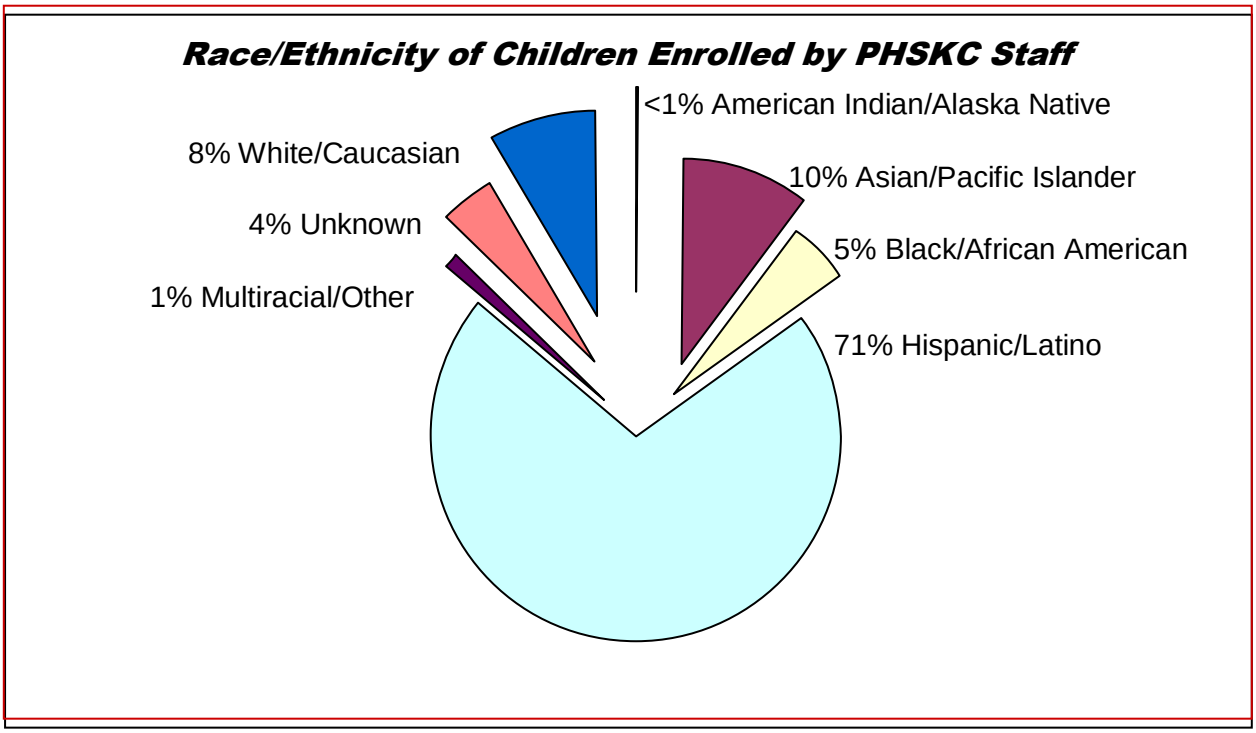
"By training others to work with families on their applications and figure out what's needed to get them enrolled, we're expanding our capacity multi-fold."

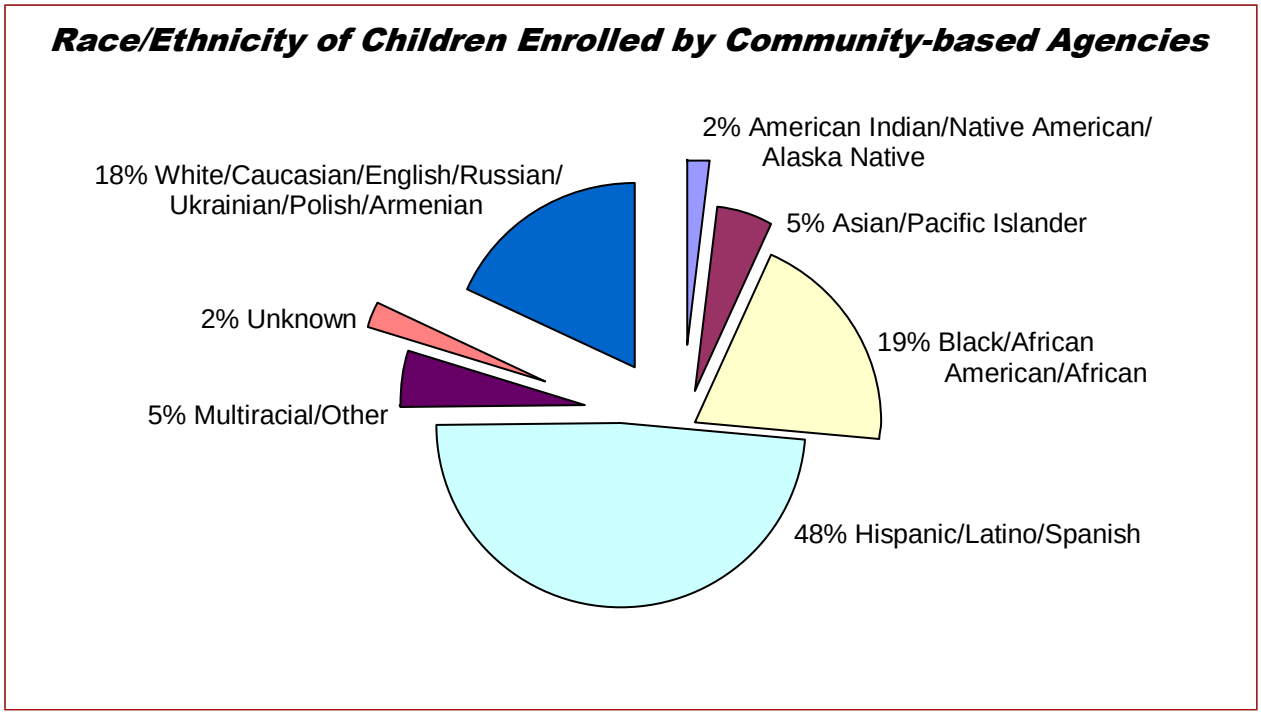
–Access & Outreach Supervisor

Health Planning Area	Number of Enrolled Children	Percent of Enrolled Children	Health Planning Area	Number of Enrolled Children	Percent of Enrolled Children
Auburn	203	3%	Lower Valley & Upper Snoqualmie	12	<1%
Ballard-Fremont-Greenlake	51	1%	Mercer Island/Point Cities	2	<1%
Beacon & SE Seattle	263	4%	N Seattle/Shoreline	152	2%
Bellevue	63	1%	NE Seattle	39	1%
Bothell/Woodinville	63	1%	Queen Anne/Magnolia	26	<1%
Burien/Des Moines	459	7%	Redmond/Union Hill	12	<1%
Capitol Hill/Eastlake	4	<1%	Renton	367	5%
Cascade & Covington	131	2%	Southeast King County	20	<1%
Downtown & Central	104	2%	Tukwila/SeaTac	184	3%
Federal Way	2,929	43%	Vashon Island	10	<1%
Issaquah/Sammamish	20	<1%	W Seattle/Delridge	192	3%
Kent	971	14%	White Center/Boulevard Park	498	7%
Kirkland	26	<1%			



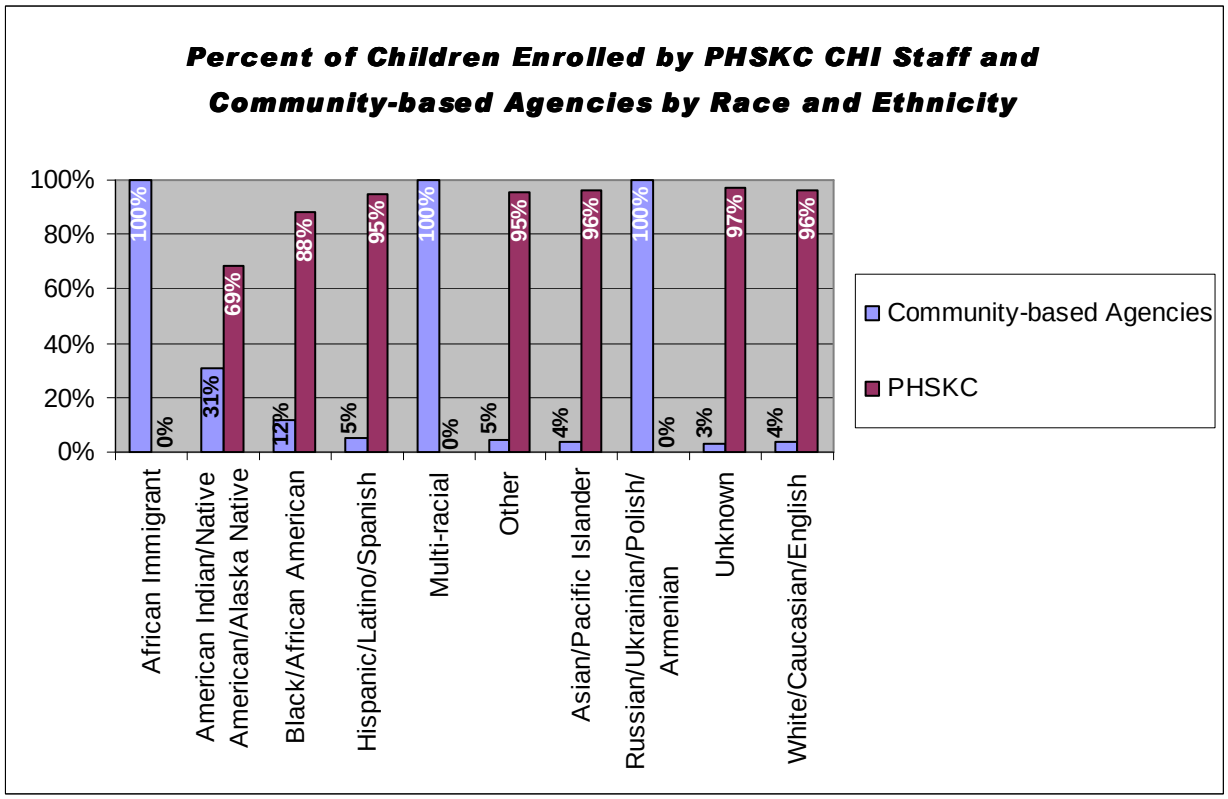
Both PHSKC CHI-funded staff and the community-based agencies that the CHI contracted with were successful in enrolling children from diverse racial and ethnic communities. Overall, PHSKC CHI staff were responsible for approximately 93% of the children enrolled through the CHI. Most (71%) of these children were Hispanic/Latino. In comparison, no one racial group represented a majority among the children enrolled by community-based agencies, where enrolled children were 48% Hispanic/Latino, 19% Black/African American, and 19% White/Caucasian. The charts below and on the following page show the race and ethnicity of enrolled children over the 2007 – 2009 time period.





PHSKC and community agency staff did not record race and ethnicity in a uniform way. For example, some agencies listed only race, while others listed only ethnicity or language. In order to facilitate comparison, the preceding charts combine several racial and ethnic categories, which likely contributes to a degree of inaccuracy. For example, all of the children that community-based agencies coded as African immigrants are included in the Black/African American category, although their race is unknown. Similarly Russian, Ukrainian, Polish, and Armenian immigrant children are grouped with White/Caucasian children. However, although the categorization may contain inaccuracies, comparison of the two charts shows that while the children that PHSKC staff enrolled were comparatively more likely to be Hispanic/Latino or Asian/Pacific Islander, children enrolled by community agencies were comparatively more likely to be American Indian, Black/African American, or White/Caucasian.

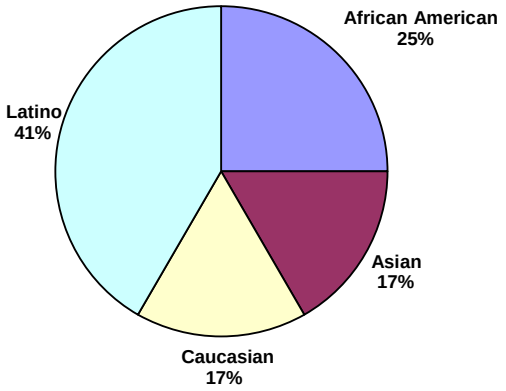
A key goal for the CHI is ensuring access to care for communities more likely to be uninsured and that experience greater barriers to accessing medical and dental care due to language or culture. Therefore, it is important for the CHI to consider the impact on enrollment of racial and ethnic groups in making decisions about the best outreach and enrollment strategies. The chart on the following page shows the contribution of community-based agencies compared to PHSKC staff in enrolling different racial and ethnic groups. PHSKC staff are responsible for enrolling the vast majority of children in most racial and ethnic categories, for example, enrolling 96% of the Asian/Pacific Islander children. The one category in which community agency staff were more successful was enrollment of Native American/Alaska Native children. Of the 32 Native American/Alaska Native children enrolled through the CHI, 69% were enrolled by PHSKC staff and 31% through community-based agencies.



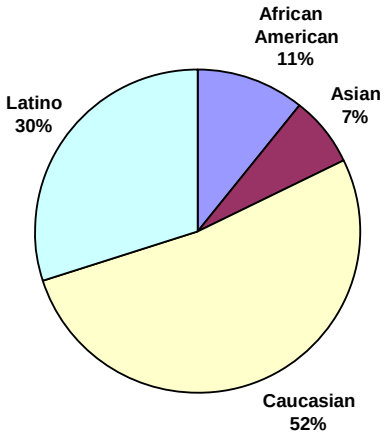
The differences in how community agencies coded race and ethnicity make it difficult to compare enrollment of immigrants. While some of the community-based agencies tracked their enrollment of African, Russian, Ukrainian, Polish, and Armenian immigrants, other agencies and PHSKC's CHI staff recorded race only—entering these children within broader White/Caucasian and Black/African American race categories. The preceding chart shows enrollment of immigrant children for the agencies that recorded this information separately; however, it would be incorrect to infer that PHSKC staff did not enroll African, Russian, Ukrainian, Polish, and Armenian immigrants.

Research has shown that outreach to families is often more effective when outreach staff speak the families' language and share their ethnicity. Therefore, many public health programs strive to hire staff that share the language and ethnicity of the communities they target for outreach. Analysis of enrollment data shows that the ethnicity of PHSKC CHI staff correlates with the ethnicity of uninsured adults in King County (data on the ethnicity of uninsured children in King County is not available). As the following charts show, PHSKC CHI staff were slightly more likely to be Latino than the uninsured adult population and considerably more likely to be African American or Asian. PHSKC CHI staff were significantly less likely to be Caucasian as compared to the uninsured adult population.

Ethnicity of PHSKC CHI Staff



Ethnicity of Uninsured Adults in King County



Source: BRFSS—King County adults aged 18–64, for the years 2006–2008 combined. Accurate data for uninsured children is unavailable.

Establishing a Medical and Dental Home

The CHI has worked with DSHS throughout the past three years to obtain accurate state data to calculate the percentage of enrolled children who establish medical and dental homes. Many of the data issues have been resolved, but the 2007 and 2008 data shown on the following page should be considered preliminary, as the available data from DSHS are inconsistent.

Analysis of the data available, however, shows that 73% of children enrolled in public health insurance through the CHI through 2008 had established a medical home (defined as one visit to a physician) and 40% had established a dental home (defined as one visit to a dentist). This rate will likely improve over time as data from claims continue to become available. Interviews with CHI-enrolled families, for example, found that only 3% reported that their child had not received care, suggesting that children in 97% of the interviewed families may have established a medical home.

Children Enrolled by the CHI (through 4th Quarter 2008)	Number	Percent
Children With a Medical Home	2,662	73%
Children Without a Medical Home	964	27%
Children With a Dental Home	1,466	40%
Children Without a Dental Home	2,160	60%

These results are comparable and in some cases higher than findings from counties in California with similar Healthy Kids programs. The following table shows the percentage of children who established a medical home with the Healthy Kids program, compared to the percentage of children with a medical home without the program.

County	Percent of Children with a Medical Home with Healthy Kids	Percent of Children with a Medical Home without Healthy Kids
Los Angeles	76%	70%
San Mateo	59%	42%
Santa Clara	54%	32%

Preventive Health Improvements in Safety Net Clinics

To support the overall goal of improving children's health status, the CHI contracts for care coordinator positions in six safety net clinics. These care coordinators use quality improvement techniques to expand the delivery of comprehensive preventive services, remove barriers to care, and ensure children's completion of treatment. In the future, data will measure changes in immunization rates, oral health visits, and well-child checks for all children enrolled by the CHI. In the meantime, since data on the outcomes in these areas are not yet available for the children enrolled by CHI as a whole, data from the safety net clinics with care coordinators provide some useful reference points about the results for four of the objectives, which is shown in the measurement and evaluation table beginning on page 20.

The safety net clinics with care coordinators were asked to select and report on two of the preventive health measures. Data on the measures reported by these clinics are not exclusively composed of CHI-enrolled children, but of all children served at those clinics. The improvements in their delivery of early preventive care are substantial. The chart on the following page shows the objectives and the rates of change for each clinic that reported on the measure.

Objective	Rates of Increase at Clinics, from Contract Start to Dec 2008*
Increase the number of children with an oral health visit by age 1	42%, 49%, 114%, 257%
Increase the number of fluoride applications for children	For age 0–5: 17% and 104% For age 6–10 : 79%
Increase the number of children with up-to-date immunizations	6%, 22%, 63%, 79%
Increase the number of children age 0–5 who receive a structured developmental assessment	3% (from 87% to 90%)
Increase the percentage of 3–6 year old children who are up-to-date on EPSDT visits	4%, decrease of 13%

*Contracted clinics were asked to choose two of these five areas for improvement. Data on the measures reported by clinics with care coordinators are for all children at those clinics, not just CHI-enrolled children. Objectives varied in percent improvement depending on the clinic's baseline.

Effectiveness of CHI Strategies: 2009 Process Evaluation

A process evaluation conducted in 2009 provided insight on which strategies were most important in making the CHI's Access and Outreach component successful. The report's findings are included in the appendices. The report categorized the CHI's Access and Outreach strategies into four primary components:

- Step One: Locating low-income families and informing them about the availability of health insurance coverage for their children
- Step Two: Assisting families with the application and enrollment process
- Step Three: Helping families connect with a healthcare provider for their children
- Step Four: Teaching families about the importance of preventive care and ensuring that children receive preventive services

Looking at Access and Outreach as a whole, the 2009 process evaluation included the following overall systems conclusions:

Supervisory Structure

- The provision of funding for supervisory positions is an important ingredient in achieving accountability. The current supervisor to outreach and application worker ratio of 1:4 or 1:5 allows supervisors to provide individual support and training for staff.

- By making effective use of the existing trained staff and supervisors at PHSKC, the effort avoided many of the pitfalls of other new initiatives, particularly a slow start and disappointing results during the early years.

Outreach Staff

- The recognition that the Access and Outreach jobs are complex in nature and require significant skills in system negotiation, advocacy, client education, and creative problem-solving leads to hiring and retention of a strong staff group. Successful staff in these positions are detail-oriented with good people skills, strong computer skills, in-depth understanding of the Medicaid eligibility rules, and are familiar with community resources in order to make effective referrals.

- Provision of support staff to assist the outreach workers with the clerical activities that are part of the outreach and application processes frees up outreach worker time to enroll additional families and help link them to care.

- Delivery of staff training at community agencies such as schools, along with the provision of tools and information, helps develop stronger identification and referral, and in some cases, enrollment expertise among the Health Department's community-based partners.

Performance Measures

- The Health Department's Program has been more productive and registered lower per-unit costs in enrolling families in health coverage and linking them to care than the community-based organizations under contract to perform these functions.

- Establishment and use of clear performance standards for the program staff and tracking performance against these standards on a regular basis provides critical accountability for staff and managers.

Relationship with DSHS

- The commitment to working in partnership with DSHS and community service office (CSO) staff is essential to ironing out the system-level problems that eat up so much of the Access and Outreach staff's time and energy. While the relationship with DSHS and CSO staff has improved, the time that CHI staff spend negotiating with state staff for approval of client applications is an enormous drain on the system.

- The weakest link in the application/enrollment/renewal process appears to be the prompt from DSHS for renewal—alerting families about the importance of recertifying their eligibility. This results in families losing their coverage and repeating the application and enrollment process.

Program Management

- As it was formed through a merger of two existing programs, implementation of the program occurs in multiple organizational units within the Health Department. This division of responsibility is coordinated effectively by the managers currently in place, whose strong informal relationship helps to ensure that the program functions smoothly. However, this coordination would require attention if staff changes over time.

Based on analysis of outcomes and cost efficiency at the end of 2008, PHSKC discontinued contracts for community health workers for most of the community-based agencies funded through the CHI. The process evaluation also analyzed Access and Outreach strategies from the perspective of cost and total numbers of children enrolled. In order to make a rough comparison, the analysis excluded costs such as the salaries of supervisors and the program manager and counted units of service as a combined number of enrolled children, children linked to a physician, and children linked to a dentist.

The analysis found that CHI PHSKC staff enrolled a higher number of children in coverage and cost less per unit than community-based agencies, with 4,664 units of service and a cost per unit of $73 for CHI PHSKC staff compared to 636 units of service and a cost per unit of $215 for community-based agencies. The CHI PHSKC staff's outreach efforts may have incurred lower costs for a number of reasons, including longer experience in this task, the amounts of funding provided, and/or previous experience with performance-based accountability approaches. It is possible that CBOs may be highly effective in identifying and informing many families about their potential eligibility for coverage, who then apply on their own or with assistance from other sources. However, unless the CBOs help the families complete the application process, their impact on application and enrollment will not show up in the data that is available.

The Promotora Program, CHI's Spanish-speaking community volunteers and which has been operating for one year, seems promising with 642 units of services delivered at a cost per service of $124, particularly given that costs per service are often higher in the start-up year. The promotoras were also highly effective in connecting children to medical and dental homes, including children who already have coverage but are not accessing care. Since the completion of training in July 2008, the promotoras have helped families with 424 physician and dentist appointments for their children.

Challenges

Over the last three years, the Access and Outreach team has encountered both challenges and many lessons learned. The challenges occurred in four main areas: state systems, the economy, issues concerning schools, and availability of data to track progress and results.

State Application and Renewal Processes

- The most common barriers to successful applications are income verification, citizenship documentation, and signature.
- The renewal process results in far too many children losing coverage each month, creating time-consuming and expensive re-enrollment processes, including assisting with plan and provider changes when families are re-assigned to different providers, and loss of continuity of care.
- The CHI found that 38% of the children it enrolled had previously been covered by Medicaid. While the CHI's work with the children in this category is helpful in ensuring that they retain and regain their coverage, the large number of children in this category illustrates a need to improve renewal procedures to better retain children in coverage.
- The error rate in applications denied is high. CHI staff spend a considerable amount of time communicating with DSHS staff about the correct application of eligibility regulations.
- Budget reductions have led to delays in application processing time.

- With the large increase in volume of Basic Food applications (due to eligibility increases and the economy), many more families are applying for both Basic Food and Children's Medical. These applications are processed by the local CSO, which is slower and less accurate than the Medical Eligibility Determination Section to which applications for Children's Medical only are sent.

- All of these issues result in CHI Access and Outreach staff spending more time on the enrollment process than might otherwise be true—leaving them with less time to help link families and children to care and moving children toward health improvements.

Economic Downturn

- The large volume of newly unemployed and newly uninsured families has kept staff extremely busy processing applications—leaving less time for outreach to harder to reach populations, linkages to medical and dental care, and health improvement efforts.

- The state and county budgets are experiencing significant deficits which has decreased funding for PHSKC and for state outreach activities.

> "The volume of families that need health coverage for their children due to job losses is growing steadily. The volume of service requests the Program is seeing today is significantly greater than it was six months ago."
>
> *–Access & Outreach Supervisor*

- With King County's funding for CHI Access and Outreach activities scheduled to end in December of 2009, and the need for the program's activities remaining high, CHI managers have worked to plan and secure funding for a pared-down and sustainable program for the future.

Schools

- King County's 19 different school districts, each with their own data systems, policies, and procedures, make it very difficult to work systematically with schools, requiring differing strategies and interactions with each district.

- The interpretation of DSHS staff of the guidance from the Center for Medicaid and Medicare concerning Medicaid Administrative Match (MAM) funds, makes it extremely difficult to partner with school districts that also receive MAM funds—which includes all major south King County districts. Currently, in order to honor the partnerships created and responsibly serve the community, but also comply with the state interpretation, PHSKC provides services without claiming match funds for outreach. This will not be a sustainable option in the future when funds are more limited.

Data Availability

- Although the DSHS data analyst works hard to problem-solve with CHI staff and despite the data share arrangement in place, data remain inconsistent and are not available in a timely fashion—making it difficult to conduct the analysis of children establishing medical and dental homes. The delayed data, due to a lag time of up to 18 months for claims to be submitted and reported, makes it almost impossible to use the data for its other intended purpose, which is to follow up with families who have not established care. When CHI staff follow up with families that have no record of a medical or dental visit using the most recent data from DSHS, many families state that their children have already seen a physician or dentist, but these visits are not yet included in the reported data. A new approach to statewide reporting on medical and dental linkage is needed to achieve the state goals of not only providing healthcare coverage for all children by 2010 but linking them to medical homes and improving their health.

Lessons Learned

- Getting children insured and into care requires sustained efforts to identify and enroll uninsured children, educate families about the importance of health coverage and preventive care, and provide families with information about how to navigate the health system.

> "If they know someone is going to follow up to check on them, they're more likely to follow through and do it. I was on welfare growing up, so I know that mindset. I tell them I know what reality is. Teeth aren't always that important when rent is due and your car broke down. Knowing that the follow up call is coming provides that extra motivation."
>
> *–Access & Outreach Worker*

- The CHI experience reinforces what research has shown to be true, that outreach and enrollment efforts are most successful when done continuously as an on-going process rather than a time-limited campaign. Until universal coverage exists there will always be newly eligible families, and until the enrollment and retention systems are radically simpler, families will require help in order to successfully enroll their children. Stopping and starting enrollment efforts is costly, ineffective, and destroys families' trust.

- It is important to target difficult to reach populations who may be geographically or culturally isolated from care and mainstream messages about the availability of coverage. Without targeted efforts, access and outreach will only enroll and link the easiest to reach families.

- Advocating for families, particularly in the application process with DSHS, is critically important. Staff time and effort to follow-up on applications help ensure that eligible children get enrolled.

> "A Mount View child, who was very sick, was connected with a doctor that was able to treat him. He had missed school for five days and, because the mother assumed her children were not eligible for insurance, she had not taken him to the doctor. With no income, no way to transport her family, and limited English skills, she was completely lost."
>
> *–CHI Outreach Worker*

- CHI managers have found that investments in robust outreach make it possible to achieve substantial gains in enrollment. They believe that, while this type of one-on-one targeted outreach will always be necessary to serve the most difficult to reach populations, greater results could be achieved if federal and state systems for enrollment were streamlined and automated. This would make it possible to use available funding more efficiently by providing one-on-one assistance only for those families with multiple barriers and freeing up resources to link children to medical and dental homes and improve their health.

- Partnering with community organizations and schools extends the reach of a small staff in a large county. There are only so many hours in a day for CHI workers to seek out and help families with applications and navigating the healthcare system. Without the community partners, many fewer families would have been enrolled in coverage and linked to care.

- The promotoras expand outreach to parts of the community that may not trust social service agencies a great deal or that may have other barriers in reaching services. They are effective in reaching out to Latino families, many of whom may be unwilling to seek assistance at a mainstream agency.

- Emphasizing the linkage step in the process is important. While many families can make their way to a physician or dentist, many others face significant barriers to connecting with a provider and some have

had negative experiences in the past that impede them from making and keeping the appointments their children need.

- Making sure that children receive preventive services—both CHI-enrolled children and all children that receive services at safety net clinics—is important to improving children's health in King County.

- Clear performance standards and regular tracking provides critical accountability. The supervisory infrastructure in King County's program, and its strong focus on accountability, may be a key factor in the productivity shown by the outreach workers. In addition, the county's utilization of a data tracking system supports performance measurement.

- The depth of experience among the CHI's Health Department staff, the funding and infrastructure for their consistent supervision, and the supervisors' focus on accountability, performance standards, and data tracking likely contributed to the higher productivity and cost-effectiveness of the Health Department Access and Outreach team in enrolling families in coverage and linking them to care.

- Major state-wide system changes such as express lane eligibility, self declared income, and automatic renewals are needed to simplify enrollment for most children, allowing local outreach workers to focus on the most vulnerable families and assuring linkage to medical and dental homes.

Advocacy & Alignment

Purpose

The Children's Health Initiative works in partnership with community coalitions and the State of Washington to increase low-income children's enrollment in publicly-funded health insurance and to improve their access to preventive and primary medical and dental services. A critical element in this partnership involves advocating with federal and state-level elected and appointed officials to achieve passage and implementation of laws that increase the number of children who are eligible for publicly-funded insurance. Passage and implementation of such laws is an essential step in reducing the significant disparities in children's health by race, ethnicity, region, and income in King County and throughout the state.

> "The families and system advocacy that we do with DSHS are invaluable. It's critical that we help individual families navigate the system, but seeing things that aren't working and bringing it to DSHS' attention helps everyone, not just the families we're working with. And it really works now that we have established a relationship, a partnership, with DSHS."
>
> *–Access & Outreach Supervisor*

Since its inception in 2007, the CHI has worked to expand healthcare coverage for low-income children, improve eligibility and enrollment systems, and increase recognition of the importance of preventive care for children. These advocacy efforts became even more important as the economic environment worsened in 2008 and 2009 and the recession caused millions of families to lose health coverage. Nonetheless, there were also victories during this challenging time, including the passage of a federal children's health coverage expansion (the Children's Health Insurance Program Reauthorization Act of 2009), the Obama administration's stimulus package which provided substantial increases in federal Medicaid funding, and Washington State's passage of House Bill 2128 which raised income eligibility to 300% FPL.

The CHIPRA legislation, one of the first laws signed by President Obama, includes funding for outreach grants to organizations that help low-income families who may be eligible for publicly-funded benefits. In addition, states will receive bonus payments if they adopt administrative streamlining measures, such as express lane eligibility, as part of their outreach efforts. CHI staff and community partners will continue to work with the state to ensure implementation of as many of the administrative streamlining measures as possible. These improvements will enable thousands of children across the state to gain and retain health coverage. In addition, the CHIPRA legislation includes grant funding for outreach.

Results

The focus of CHI's advocacy work over the last year was to ensure that the state's implementation of strategies, policies, and budget priorities supported increased access to healthcare for all children, despite the substantial economic slowdown. The resulting advocacy efforts included:

- Maintaining support for state outreach funding despite state budget fluctuations

  In the face of a $9 billion state deficit and with subsequent assistance from the federal government in the stimulus package, the eligibility expansion from 250% to 300% FPL and outreach funding were cut, reinstated, delayed, and finally retroactively implemented. State outreach funding will continue during the next two year period but at about half the level of the last biennium—$2.2 million for two years,

compared to $4.4 million in the past. CHI staff closely tracked and worked collaboratively with state staff and community advocates to influence these state actions.

- Contributing to the development of children's health priorities for the 2010 legislative session through leadership activities with the Health Coalition for Children and Youth

- Testifying and working to support the passage of HB 2128 to expand children's coverage, which was successful even during the economic downturn

- Testifying and supporting WithinReach's organizion of support for the passage of electronic signature legislation, which will enable true online enrollment, through HB 1270

- Working through CHI Steering Committee members' federal connections to support a federal CHIPRA feature that allows dental-only coverage for CHIP children who have private medical coverage but no private dental coverage

- Representing the local government perspective on a national Kaiser Commission for Medicaid and the Uninsured panel

- Serving as an example of a successful community-based public health initiative in a recent Trust for America's Health state-by-state list created to support federal health care reform efforts

- Disseminating CHI evaluation results

  Two CHI presentations, one on outreach findings and one on the promotoras' experiences, are upcoming at the November 2009 American Public Health Association meeting in Philadelphia. The CHI also reported results to the Kellogg Foundation to disseminate findings regarding methods to increase developmental screening and preventive dental care among low-income children.

- Advancing online enrollment for health coverage and other public benefits

  CHI's efforts to advance the concept of online enrollment in Apple Health through ParentHelp123 has helped to inspire an initiative by philanthropies, community organizations, and the state to use technology to help low-income families gain access to resources, including tax credits, health care, nutrition supports, child care subsidies, income supports, and college loans and scholarships. This initiative is also incorporating the model of public-philanthropic collaboration used by the partners who created the CHI.

Electronic Signature Legislation

On January 26, 2009, CHI staff and the King County lobbyist submitted written testimony to state House and Senate committees that were considering legislation to permit the use of electronic signatures (HB 1270). This legislation will allow electronic signatures for online applications for Medicaid and the Basic Health Plan and will greatly improve the functionality of online enrollment systems.

CHI and a number of community partners attended the bill signing on April 24, 2009.

April 24, 2009 bill signing for HB 1270 to permit electronic signatures for Medicaid and the Basic Health Plan in Washington State. From left to right accompanying Governor Christine Gregoire: Kirsten Wysen, CHI staff-PHSKC; Patty Hayes, WithinReach; Preston Cody, Basic Health Plan; Rep. Tami Green; Nancy Newcomb, Basic Health; Kelly Foster, Basic Health; Mary Fliss, PEBB Program, Health Care Authority and Teresa Mosqueda, The Children's Alliance.

Children's Health Bill Legislation

On February 3, 2009, CHI staff provided testimony regarding the King County Children's Health Initiative to the Health and Human Services Appropriations Committee Work Group and expressed the importance of continuing to invest in outreach. CHI staff explained that state outreach dollars allow local communities to enroll children in coverage and provide access to the services that can improve their health. This increased access to care can save money for the state and safety net providers by linking children with preventive services that have the potential to reduce the demand for avoidable and expensive acute care.

The final version of HB 2128 that passed the legislature on April 22 strengthens the Apple Health for Kids program by taking full advantage of federal funds, encouraging improved enrollment and renewal procedures, and creating a buy-in coverage option for families with incomes over 300% FPL. The new law also requires monitoring and reporting on children's health status to ensure that their health is improving with coverage.

On May 12, CHI staff, many HCCY members, and the sponsoring legislators joined the governor for the bill signing at the Seattle Aquarium.

May 12, 2009 bill signing for HB 2128 to support and strengthen Apple Health for Kids. From left to right accompanying Governor Christine Gregoire: Lisa Podell, Lan Nguyen, Annique Lennon, Pam Crone, Representative Larry Seaquist, Sofia Aragon, Laura Smith, Susan Johnson, Teresa Mosqueda, Molly Belozer, Erin Burchfield, Tom Byers, Laurie Lippold, Representative Dave Quall, Senator Claudia Kauffman, and Senator Jeanne Kohl-Welles.

Communities Connect Initiative

Through the Communities Connect Group Health Outcomes Grant Project, CHI staff worked collaboratively with other coalitions across the state to develop a common set of evaluation measures for access and outreach programs.

"The Health Coalition for Children and Youth has played an important role in addressing major policy issues related to health insurance coverage for children. The coalition is a strong advocate in resolving organizational barriers at the state level, particularly related to DSHS programs and policies. "

–Public Health Department Manager

Health Coalition for Children and Youth

CHI staff worked with the HCCY to help develop and inform the 2009 and 2010 state legislative agendas. The legislative agenda identified full implementation of the 2007 Cover All Kids law as its highest priority. Specifically, HCCY worked during the 2009 legislative session to increase eligibility for Medicaid and CHIP to 300% FPL, to continue funding for outreach activities to identify and enroll families in health coverage, to increase funding for children's developmental screening, and to expand mental healthcare to all children receiving state medical coverage through Apple Health. As follow-up to the 2009 state legislative session, CHI staff are working with a HCCY subgroup to monitor children's health indicators that may be responsive to the economic downturn. Reporting on the effects of the recession on children's health measures is of interest to several state legislators who support the Cover All Kids law.

Presentations at Washington State Conferences

CHI staff shared lessons learned from King County's outreach and linkage strategies at three statewide meetings in October and November 2008—the Joint Conference on Health, the Washington State Legislative Conference on Health, and the Children's Alliance Children's Health Summit. These presentations included panel discussions regarding CHI's public/private partnership, health disparities, and promising practices in outreach.

National Exposure, Consultation, and Advocacy

The CHI received national exposure as staff presented CHI outreach results, promising practices, and program principles to a panel sponsored by the Kaiser Commission on Medicaid and the Uninsured. The webcast and transcript are available at:
http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=3103

January 23, 2009, Susan Johnson at the Kaiser Family Foundation's Commission on Medicaid and the Uninsured's panel of Children's Health Coverage along with Jay Berkelhamer, President of the American Academy of Pediatrics.

Two national groups contacted CHI staff to learn more about the approaches used by the CHI—one convened by a professor at Robert Morris University and another at The Health Technology Center (HealthTech), a nonprofit education and research organization established in 2000 to advance the use of beneficial technologies in promoting healthier people and communities. HealthTech is working on a project documenting successful outreach approaches for The Children's Partnership, a national nonprofit child advocacy organization working to ensure that all children have the resources and the opportunities they need to grow up healthy and lead productive lives.

Throughout the past months, CHI staff have advocated with national groups coordinating efforts for a successful reauthorization of the CHIP legislation. Following the inauguration of President Barack Obama, not only was outreach funding included in the reauthorization bill, but also a corrective amendment to allow

children covered by stand-alone medical insurance to receive Medicaid dental coverage. This gap in coverage was identified as a problem more than a year ago during the implementation of CHI's KC Kids Dental program. The Washington Dental Service contributed to the successful advocacy for this modification to the CHIP program, which will improve children's access to dental coverage.

The CHI was used as an example of a successful community-based public health initiative for the Trust for America's Health advocacy supporting national health care reform efforts that propose to invest more in public health and prevention efforts. More information is available at: http://healthyamericans.org/health-reform.

The CHI received acclaim from Scott Armstrong, CEO of Group Health Cooperative, who spoke at a press conference supporting the need for increased funding for public health, citing the CHI as a notable example of what public and private sectors can do together to reduce healthcare costs and improve health. In September 2008, the CHI was singled out for recognition in a publication of the American Hospital Association on children's health coverage, titled *Covering Kids and Families*, which includes information about King County's CHI and can be found in the Appendices of this report. Also in that month, CHI staff reported on the progress of the CHI to the Board of Trustees of Group Health Cooperative, which reaffirmed its support for such an undertaking and the commitment of its funding.

Access to Benefits Initiative

The CHI's efforts to advance the concept of on-line enrollment in Apple Health through ParentHelp123 has helped to inspire an initiative by leading philanthropies, community organizations and top State officials to use "best of class" technology to help low-income families gain access to a wide spectrum of resources that extend far beyond children's health coverage. If the new initiative proves successful, families will have access to tax credits, health care, nutrition supports, child care subsidies, income supports, and college loans and scholarships in a single visit to a site equipped with an on-line portal and staff who are trained in its use. This "Access to Benefits Initiative" is also incorporating the model of public-philanthropic collaboration that was used by the partners who created the CHI.

Challenges

The 2008 – 2009 recession and the state's corresponding need to cut $9 billion from a $33 billion annual state budget presented substantial challenges to efforts to improve children's health coverage. The state will continue to fund a limited outreach investment and work towards covering all children in the state by 2010. CHI supports this investment and will continue to rely on such funding.

Offsetting the state's budget cuts were actions at the federal level, including the passage of CHIPRA, the stimulus package, and the federal budget which were key to retaining gains for children's health in our state.

Lessons Learned

In the last 10 years, much has been learned in Washington State about which types of outreach activities yield the greatest enrollment gains. It is important for all outreach organizations to know what works and what does not so that in the future limited outreach and linkage funding can be well spent. CHI staff and other experienced outreach organizations will work through HCCY to disseminate these findings and best practices.

Coalitions have proven to be extremely valuable. HCCY is a place where children's healthcare providers and advocates come together on a regular basis, find common ground, and develop coordinated state legislative priorities.

The CHI overall has provided solid tangible outcomes that help to bolster policy improvement with supporting facts and figures demonstrating program success. This approach follows the King County Health Action Plan strategy of demonstrating the value of working through public/private partnerships, using proven pilots to achieve broader policy changes.

Online Enrollment Pilot Project

Purpose

The Online Enrollment Pilot Project helps families in King County apply for and stay enrolled in public health coverage and links them to services through WithinReach's web-based screening and application tool at www.ParentHelp123.org. Currently, many low-income families face barriers to accessing coverage and services related to the paper application and enrollment process.

In 2008 and 2009, WithinReach made significant progress toward two of CHI's goals: completing the technical and policy changes needed for families to electronically submit state health coverage applications through ParentHelp123.org and completing a professional version, ParentHelp Pro, of the current web-based application tool for use by application and outreach workers enrolling families. WithinReach and CHI outreach staff will work together to develop the ParentHelp Pro application and CHI staff will select two pilot sites for beta testing of ParentHelp Pro.

> "It was easier to stay home and fill out the application online than wait at the office. The website was very user-friendly."
>
> *–ParentHelp123 user*

WithinReach's user-friendly web application, ParentHelp123, screens applicants for eligibility for both health coverage (Medicaid, CHIP, Basic Health) and food assistance programs (Food Stamps, WIC), and allows users to quickly and easily fill out multiple program applications. From August 2008 to June 2009, 7,266 King County residents using the screening website were found to be likely eligible for health coverage and 5,248 were likely eligible for Basic Food or the WIC Nutrition Program.

Users found to be likely eligible may proceed to complete the online application process. They can choose to have their application routed by WithinReach (via e-fax when possible) or to print out their own completed forms, sign them, and mail them to DSHS. More than 85% of families choose to have their application routed for them. In 2009, the online enrollment pilot project worked with state DSHS staff to address the technical and policy issues required to create a seamless electronic submission process.

WithinReach is currently developing the ParentHelp Pro software that workers and other outreach staff can use with families to rapidly fill out an application for benefits. This streamlined provider interface will allow case managers, outreach workers, eligibility workers, community health clinics, community technology center staff, and others to quickly and easily assess eligibility processes and enroll families in needed programs.

Results

- In 2008, ParentHelp123.org completed a successful pilot of an electronic connection with DSHS and the Health Care Authority (HCA) — On August 22, 2008 the first applications for Children's Medical and Pregnancy Medical coverage were faxed to the state office in Olympia that determines eligibility. On November 13, 2008 the process became entirely electronic with transmission of e-faxes rather than paper faxes. A pilot e-fax connection to the HCA for Basic Health applications is also being conducted. Electronic signature legislation passed this spring will improve the efficiency of electronic applications. Additional work resolving policy issues related to electronic submission of application information will proceed in 2009, with an expected date for true electronic submission in fall of 2009.

- Usage data indicates that families prefer to have their online applications routed to DSHS on their behalf rather than mailing their own. Following the launch of routing applications through e-fax to DSHS and HCA, there was a 60% increase in the number of completed applications. Of the families that use ParentHelp123.org, 85% choose to have WithinReach route their application to the state rather than printing and mailing their own application.

- Implementation of application and enrollment tracking — The DSHS Health and Recovery Services Administration (HRSA) provided enrollment data for children whose families had applied in September 2008 via ParentHelp123.org for Children's Medical. As of December 2008, out of the total of 663 applications submitted, 66% or 438 had been approved for medical coverage, 31% or 206 had been denied, and 3% or 19 were pending. Analysis of the reasons for denial showed that 89% of those who were denied failed to provide verification documents. This is similar to findings from an evaluation that WithinReach conducted using Basic Food enrollment and denial data. ParentHelp Pro will address this issue by incorporating more follow-up with families to ensure completion of the process.

- WithinReach recently received a unique barcode for the first time from HRSA — This will allow the organization to receive monthly reports on the number of children that are successfully enrolled in Children's Medical through ParentHelp123.org and WithinReach's call center.

- Completion of a resource tool kit to help social services professionals connect low-income families to state benefits, located at www.parenthelp123.org/professionals — The toolkit provides easy access to information, such as the latest income guidelines, applications and forms, and free outreach materials about state-sponsored heath insurance and food assistance. This resource sets the stage for the launch of ParentHelp Pro and provides a way to market the available resources. A "What's New" page alerts professionals to changes in state-sponsored health and food programs. Over 1,500 professionals receive updates via a "What's New" e-newsletter (included in the Appendices of this report).

- Development of ParentHelp Pro — This streamlined tool will provide a quick and flexible way to enter client data, screen for program eligibility, and send applications electronically to the state. To support this work, WithinReach conducted initial focus groups with community outreach organizations and obtained data requirements from PHSKC outreach staff. Plans are underway for beta testing in the fall of 2009. PHSKC will select two sites to pilot ParentHelp Pro.

- WithinReach is also adding service programs to both the family website and ParentHelp Pro, including Temporary Aid to Needy Families, Head Start, Working Connections Child Care, and Family Planning/Take Charge. The system will allow customization so that user groups can include screening and applications for local programs such as the City of Seattle's Childcare Payment Assistance Program.

- Beta testing of the state's improved Online Community Service Office—WithinReach participated in the state's testing of its Online Services Access Project in January 2009. The state asked stakeholders to assist in testing the system and provide feedback in lieu of end-user testing. Testing of the Online CSO is complete and the system is now live. The state can now process client data electronically. WithinReach will continue to work with DSHS to create the capacity to electronically submit ParentHelp123.org data.

The chart below summarizes the program's results in relation to the goals and measures established at the initiation of the pilot.

Goals	Measures	Results
ParentHelp123.org establishes an electronic link to allow families the ability to submit applications to the state electronically	ParentHelp123's electronic submission feature is functional	August 22, 2008: application routing feature is launched November 13, 2008: e-faxing of children's applications is launched
Families are able to submit health/dental care coverage applications for their children online	Number of submitted applications for children under age 19 (by site, by region in King County, and by ethnic group)	Statewide: 5,268 applications submitted King County: 1,109 applications submitted
	Number of accepted applications for children under age 19 (by site, by region, and by ethnic group)	In 4th quarter 2008, 66% of submitted applications were approved
Outreach and application workers are able to use the "super-user" version of ParentHelp123 to submit health/dental care coverage applications for their clients	Number of outreach and application workers that use, "subscribe", or have a log-in to the super-user version	1,500 outreach and application workers receive "What's New" newsletter Additional data will be available in late 2009
	Number of children whose applications are submitted and approved by outreach and application workers via ParentHelp123 (by site, by region, and by ethnic group)	Data will be available in late 2009
Families enroll their children in the new WDS dental program	Number of children that are referred to the WDS dental program website via ParentHelp123	ParentHelp123 linked to the KC Kids Dental website during 2008, but data on the number of hits is not available

In addition, between August 1, 2008 and June 3, 2009:

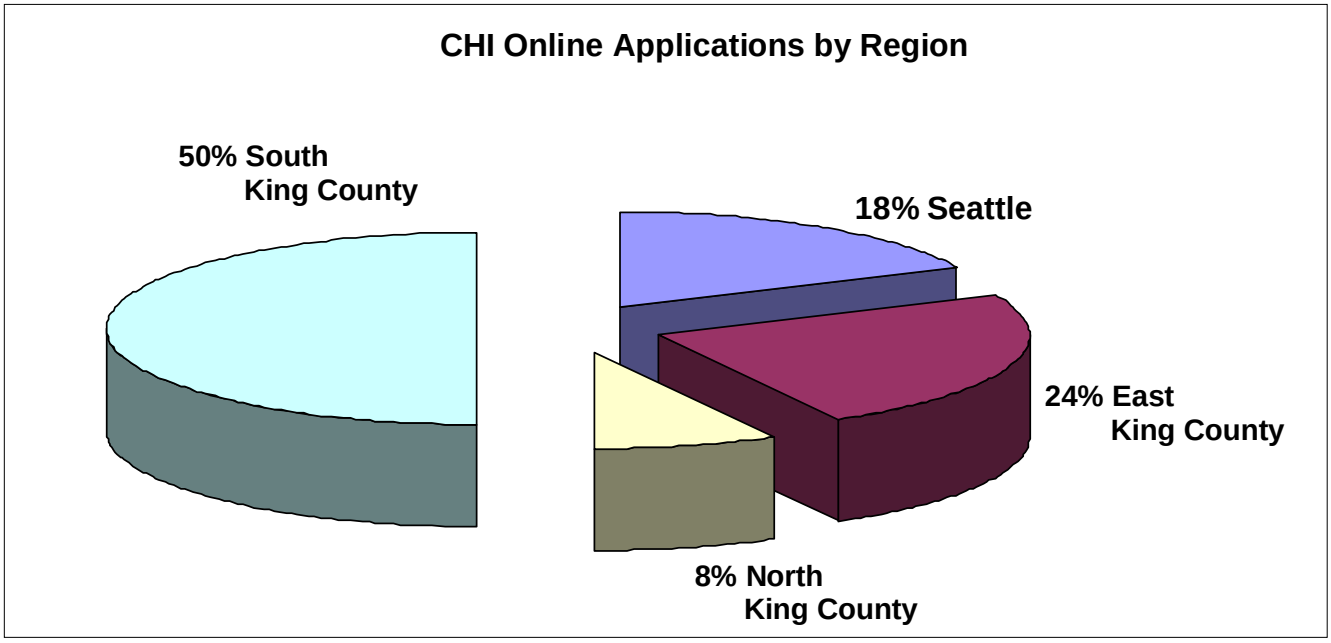
- There were over 42,000 visits to www.ParentHelp123.org.
- 85% of those using the screening and application tool were using it for themselves or their family.
- 64% of those that were screened applied for health and/or food benefits.
- The average time to complete the screening and application process was about 15 minutes.
- 85% of site users chose to have WithinReach route their application for them.

The following chart shows the number of individuals found to be likely eligible for health insurance and food assistance.

Programs	Washington State	King County
Health Insurance (Apple Health, Basic Health, and First Steps)	28,741	7,266
Food Assistance (WIC and Basic Food)	20,141	5,248

Analysis of the geographic distribution of King County residents who used the online screening and application process shows that the pilot project reached families throughout the county. The greatest proportion of families using online enrollment lived in Renton (11%), followed by Auburn (9%), Bellevue (9%), and Kent (9%).

Applicants through Online Enrollment by Health Planning Area	Number	Percent	Applicants through Online Enrollment by Health Planning Area	Number	Percent
Auburn	103	9%	Lower Valley & Upper Snoqualmie	33	3%
Ballard-Fremont-Greenlake	29	3%	Maple Valley	27	2%
Beacon & SE Seattle	46	4%	N. Seattle/Shoreline	57	5%
Bellevue	95	9%	NE Seattle	25	2%
Bothell/Woodinville	14	1%	North Bend	18	2%
Burien/Des Moines	55	5%	Queen Anne/Magnolia	9	1%
Capitol Hill/Eastlake	9	1%	Redmond/Union Hill	39	4%
Downtown & Central	21	2%	Renton	123	11%
Enumclaw	18	2%	Southeast King County	7	1%
Federal Way	64	6%	Tukwila/SeaTac	30	3%
Issaquah/Sammamish	59	5%	Vashon Island	8	1%
Kenmore	16	1%	W. Seattle/Delridge	29	3%
Kent	102	9%	White Center/Boulevard Pk	17	2%
Kirkland	40	4%	Woodinville	16	1%



Challenges

- The timeline for achieving seamless e-submission with DSHS remains unclear. Conversations are occurring with the governor's office and children's advocacy groups to continue to move this initiative forward. More information about the status of electronic data submission with DSHS will become available this summer.

- DSHS has been upgrading the structure of the department's internal data system. This work needed to be completed before DSHS could create a data interchange with other organizations to enable true e-submission of applications.

- Over the past six months it has been difficult for web programming to keep pace with legislative changes. For example, in December 2008, income guidelines and program descriptions were increased to prepare for the expansion of Children's Medical to 300% FPL, and then in January 2009, the income guidelines and descriptions were returned to 250% FPL. One month later, in February 2009, the income guidelines and descriptions reverted back to 300% FPL. Fortunately, ParentHelp123 has a robust administrative feature that allows for easy management of income guidelines and program descriptions which allows WithinReach staff to respond to changes in program guidelines quickly.

> "It was helpful because I didn't have any idea how to apply. I had a friend that told me about the website because she used it, and it was easy to use."
>
> *–ParentHelp123 user*

Lessons Learned

- More challenging than staying current with changes in program guidelines is the impact of changes on client expectations. WithinReach stays closely connected to state programs and participates in multiple outreach workgroups to stay informed on the latest updates from state agencies. Over the past year it

has become clear that having a call center to support online services is critical in providing the necessary support to families. WithinReach's Information & Referral Specialists are able to help families interpret quickly changing program requirements so that they can make informed decisions about applying for state benefit programs.

- During these challenging times state agencies may be short staffed due to state hiring freezes and increased work load. Community agencies play a key role in the safety net for families and are a critical partner in making sure that families do not fall through the cracks.

- Policy issues that affect electronic submission of data to state agencies can be complex. WithinReach plans to learn from other states that have achieved e-submission in order to advance this work in Washington. In partnership with PHSKC policy staff, WithinReach intends to gather examples of other states' experiences with data interface agreements and attorney generals' opinions on e-submission.

A Success Story

Dave and his wife Anna* were thrilled to be the parents of a healthy baby girl but were worried because they lacked health insurance. A visiting King County Public Health nurse told Dave about ParentHelp123.org. Late that night, after Anna and the baby went to sleep, he went online to look at the site and applied for Children's Health Insurance using ParentHelp123's new paperless application process.

WithinReach staff reviews applications that come through the website to ensure that they are complete before forwarding them to the DSHS. Staff noticed that Dave had inadvertently applied for two different health insurance programs for his baby. The staff person called and explained that he could apply for one or the other, but not both, and told him about the coverage provided in each plan. Together they determined which one was the best choice for Dave's family.

Dave was relieved that his application was filled out correctly, and that soon his baby would have health insurance. In his words, "It's great to have this kind of thing available! With a full-time job and a new baby, it's not easy to get in touch with people during the workday. I don't get a chance to do things like this until late at night."

**Names have been altered to protect confidentiality.*

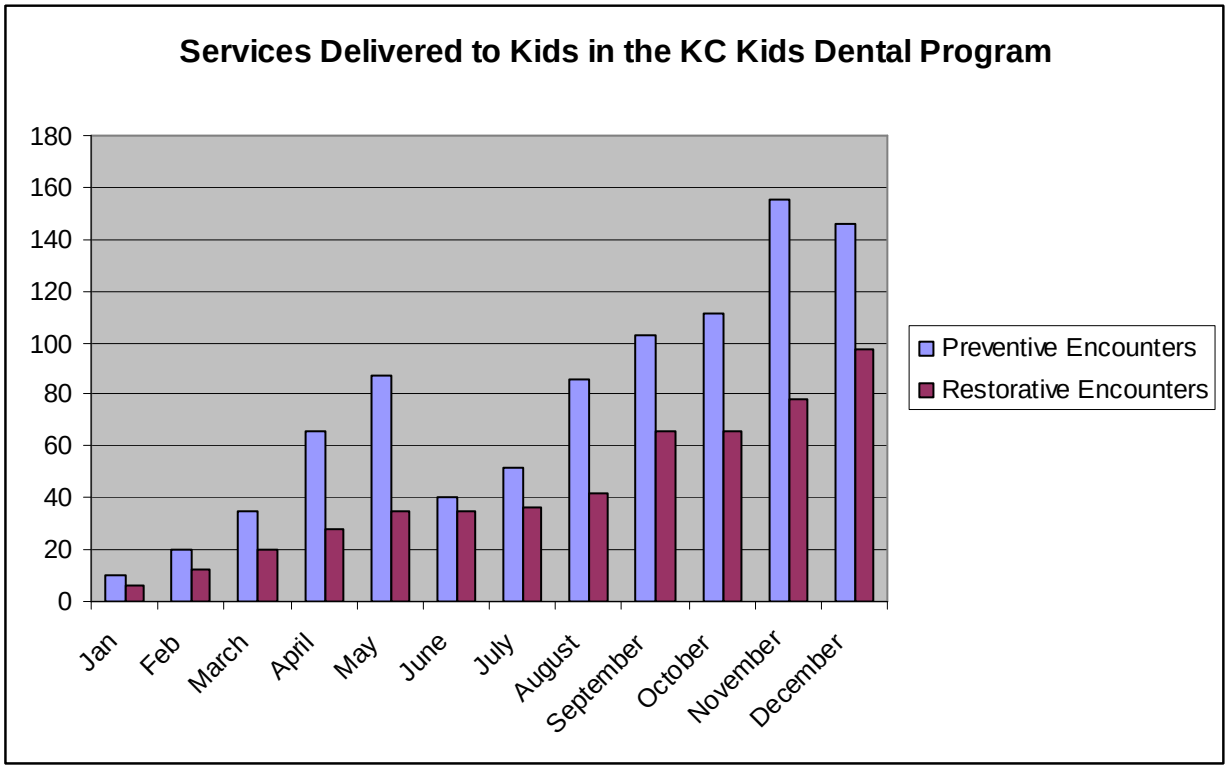
KC Kids Dental Pilot Project

Purpose

The KC Kids Dental Program, developed and administered by CHI partner the Washington Dental Service, provided no-cost dental services for eligible families throughout 2008. The program served children in King County between 250% and 300% FPL. By the end of 2008, the program had enrolled 808 of the estimated 1,000 uninsured children at this income level living in King County and 83% of enrollees had accessed a dental provider. As planned, the program ended in December 2008 when the state was slated to launch an extension of medical and dental coverage for children up to 300% FPL. Due to challenging state budget issues, the anticipated expansion of coverage did not take place as planned on the first of the year. However, by mid-February it was announced that medical and dental coverage for children between 250% and 300% FPL would go into effect and would be retroactive to January 1, 2009.

Results

More than four out of five, 671 out of 808, children who enrolled in the KC Kids Dental Program accessed dental services and 739 King County dentists participated in the program. Two-thirds of the services children received were preventive rather than restorative with a total of 911 preventive services delivered in 2008. The number of services delivered each month increased over the course of the year, as shown in the following chart.



The program's access rate for services among enrolled children appears to be quite high compared with the average rate of 67% for counties in California with Healthy Kids programs, a children's health program that includes medical, dental, and vision services. *(For more information, see: http://www.cchi4kids.org/docs/USC_Dental_Utilization.pdf.)*

The following chart summarizes the program's results in relation to the goals and measures established at its initiation.

Goals	Measures	2008 Results
Increased access to and use of dental services for children in families between 250%–300% FPL	# of children enrolled in the program	808 children enrolled (out of an estimated 1,000 children in this income bracket without dental insurance in King County)
	# of children in program who accessed services	671 children accessed services (83%)
	Type of services delivered: preventive vs. restorative	911 preventive visits 521 restorative visits
	Number of dental providers providing services to KC Kids	739 dental providers provided services to 808 enrollees
	Cost of services delivered	$537,456 cost of services delivered
Successful outreach strategies identified and employed	# of children in program identified as under income and referred to CHI outreach team	977 children referred

Outreach to families identified nearly 1,000 children that were under the income level for the KC Kids Dental Program—the program referred these families to the CHI access and outreach program. It was discovered that a significant number of these children, though eligible for the CHIP program, had medical insurance but lacked dental coverage. The CHIP program does not provide wrap-around dental coverage for these children, an issue that HIIC committee members brought to the attention of state officials.

Survey Results

WDS distributed surveys to both patients and dental care providers to measure the program's effectiveness and to assess client and provider satisfaction. Out of 305 patient surveys distributed, a total of 85 patients returned their surveys, a response rate of 28%. Out of 165 surveys distributed to participating dental care providers, a total of 37 returned their surveys, a response rate of 22%.

Survey results indicated that the program succeeded in linking enrolled families to a participating dentist and that levels of satisfaction were high among both patients and providers.

Results from the survey of patients were positive. Only one respondent registered a negative rating in one category—ability to get an appointment within three weeks. More than half of the respondents indicated that they were "very satisfied" with all of the aspects of the program that were listed.

KC Kids Survey – Patients	Very Satisfied	Satisfied	Neutral	Dissatisfied
Ease of enrolling	73 (86%)	12 (14%)		
Ease of finding a dentist	69 (81%)	13 (15%)	3 (4%)	
Ability to get appointment within 3 weeks	62 (73%)	15 (18%)	7 (8%)	1 (1%)
Dentists' ability to treat your child's needs	66 (78%)	18 (21%)	1 (1%)	
Quality of care and attention at dental office	64 (75%)	19 (23%)	2 (2%)	
KC Kids Customer Service	65 (76%)	13 (15%)	3 (4%)	

Dental providers' feedback was also highly positive. More than half of the respondents (60%) reported that they were "very satisfied" with the program as a whole. Ease of verifying patient eligibility and benefits scored slightly lower than other categories but still registered a high overall approval rate, with 89% of providers reporting that they were "very satisfied" or "satisfied" with this area of the program.

KC Kids Survey – Providers	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
KC Kids dental plan (in general)	22 (60%)	12 (32%)	3 (8%)		
Ease of verifying patient eligibility & benefits	18 (48%)	15 (41%)	3 (8%)	1 (3%)	
Administration of KC Kids Program compared to other dental plans	20 (54%)	15 (41%)	2 (5%)		
KC Kids Customer Service	19 (51%)	13 (35%)	4 (11%)	1 (3%)	
Processing and payment of claims	20 (54%)	13 (35%)	3 (8%)		1 (3%)
Patient compliance with office expectations and appointments	19 (51%)	13 (35%)	5 (14%)		

Families reported that they learned about the program through multiple sources. Schools were the most common source, but significant numbers learned about the program through other sources, including the radio, family and friends, newspaper inserts, internet, childcare, dental offices, food banks, and community centers. The KC Kids website registered over 17,000 hits during 2008 and 2,774 individuals completed the interactive form to determine eligibility for the program. Please refer to the appendices for a full report on the KC Kids Oral Health Program published by WDS.

Challenges

- The KC Kids Dental Program highlighted a concerning gap in the CHIP program. Many CHIP-eligible children (200% – 250% FPL) who have private medical insurance but no dental sought dental coverage through the KC Kids Dental Program but were not income-qualified for KC Kids (250% – 300% FPL). This is because the CHIP program, unlike Medicaid, does not allow wrap-around services.

- Traditional outreach methods to locate low-income children are not always effective for families at 250% to 300% FPL. In order to bolster efforts to locate and enroll children, WDS developed and employed new outreach strategies focusing on schools, the internet, child care centers, radio, print media, and television.

- When the KC Kids program ended in December 2008, it was anticipated that the state would extend medical and dental coverage for children up to 300% FPL. However, due to challenging state budget issues, this was delayed. By mid-February 2009, it was announced that this extension would go into effect and would be retroactive to January 1.

Lessons Learned

- Schools proved to be the most effective focus of outreach efforts to enroll children in the KC Kids Dental program.

- Online access for families in this income range appears to be an important element as evidenced by over 17,000 hits to the KC Kids website and 2,774 individuals who completed the online interactive eligibility worksheet.

- Additional service delivery points (739 dental providers accessed by KC Kids enrollees) contributed to high utilization of dental services (83%) during the one year program.

- Administrative ease in processing claims contributed to high provider satisfaction with the KC Kids Dental Program.

Maternal & Child Behavioral Health Pilot Project

Purpose

The primary aim of the Maternal and Child Behavioral Health Pilot is to prevent and treat common mental health disorders in low-income pregnant women, mothers, and their children. The pilot is a family-centered mental health screening and treatment strategy integrated into eight King County safety net clinics. Funds from two King County sources support this four-year pilot.

- The King County Human Services Levy provides core funds to address maternal depression via integrated mental health and behavioral health services in maternity support programs and safety net primary care clinics.

- Complementing levy funding, the Children's Health Initiative has provided funding to pilot screening and mental health treatment strategies for low-income children ages 0 – 12.

As many as 13% of women experience major or minor depression during the perinatal period, and estimates of the overall prevalence of depression among mothers of young children range from 12% to 50%. Maternal depression impacts all races and classes but disproportionately impacts low-income families who are vulnerable to the additional psychosocial stressors of poverty, lack of social supports, substance abuse, violence, and stress.

Depression frequently interferes with parenting practices and coping skills with many negative effects on care giving and nurturance. Research has shown that untreated maternal depression has many adverse impacts on children's healthy development.

- Untreated prenatal depression is linked to poor birth outcomes, including low birth-weight, prematurity, and obstetric complications.

- Children of depressed mothers have higher rates of depression, attention deficit disorder, separation anxiety, poor academic performance, and insecure attachment.

- Mothers suffering from depression are less likely to engage in practices like safe sleep for prevention of SIDS, using car seats, or obtaining routine preventative healthcare for their children.

The 2009 report from the Institute of Medicine estimates that depression affects approximately 7.5 million parents in the US every year, which may put the health of at least 15 million children at risk. Strategies for early recognition and intervention to prevent and treat mental and developmental disorders in high risk mothers and their children are needed.

While trends show increasing numbers of younger children requiring mental health services, primary care physicians are not always well versed in what to screen for and what interventions can be helpful at a primary care visit. In addition, there is a general lack of knowledge about early recognition of problems associated with children's social and emotional development among parents. Because of these missed opportunities (the average child sees a doctor 15 – 20 times before starting kindergarten), early

developmental, emotional and behavioral disorders are not detected, resulting in delayed treatment and potentially higher healthcare costs.

In 2007, the Washington State Legislature took action to improve children's mental health. The legislative intent statement for children's mental health services was revised to place an emphasis on early identification, intervention, and prevention, with a greater reliance on evidence-based and promising practices. The expressed goal of the legislature is to create, by 2012, a children's mental health system with the following elements:

- A continuum of services from early identification through crisis intervention, including peer support and parent mentoring services
- Equity in access to services
- Developmentally appropriate, high-quality, and culturally competent services
- Treatment of children within the context of their families and other supports
- A sufficient supply of qualified and culturally competent providers to respond to children from families whose primary language is not English
- Use of developmentally appropriate evidence-based and research-based practices and integrated and flexible services to meet the needs of children at-risk

The Maternal and Child Behavioral Health Pilot Project is leading the way in making the types of changes in children's mental health called for by the Washington State Legislature. By implementing a variety of behavioral health integration strategies in different primary care settings, the project will generate critical data to assist state and local policymakers in designing and implementing effective behavioral health programs for low-income children and families. To this end, the goals of the project are to:

- Improve access to depression screening and treatment for culturally diverse, low-income mothers contributing to improved outcomes for their children
- Improve mental health status and functioning of at-risk mothers and their children through standardized treatment protocols in primary care
- Improve primary care capacity to reduce risk, address early symptoms of maternal depression and other mood disorders, and treat mental health issues for both mothers and children

Results

Screening for Maternal Depression and Mental Health Concerns among Children

- The program screened 2,823 pregnant and parenting women for depression and mood disorders during its first 11 months.
- In the same period, 1,731 children ages 0 – 12 were screened for developmental red flags and 77 were identified as at risk of behavioral and/or developmental issues of concern.

Over 97% of mothers enrolled in the pilot programs were screened at least once for depression using a standardized, validated screening tool, the Patient Health Questionnaire (PHQ-9). The PHQ-9 is used to evaluate the presence and severity of patients' symptoms of depression. Women on current clinic caseloads have an average PHQ-9 score of 15 points, which is indicative of major depression requiring treatment through psychotherapy and/or antidepressants.

In the past year, each participating clinic has developed and tested numerous screening protocols for the PHQ-9 addressing both language barriers and cultural issues appropriate to its clinic population. All the clinics screen pregnant patients during their prenatal visits and encounters with Maternity Support staff. Some clinics have also developed successful protocols to screen mothers during their children's visits to the clinic for an acute illness or well-child care.

Other screening instruments have been used minimally thus far. Although their use is not required in the pilot, increasing the number of mothers screened for substance abuse problems or domestic violence concerns could help increase the number of mothers referred to chemical dependency treatment and other important resources.

Efficient mental health screening protocols for children ages 0 – 12 have proved challenging to develop in the pilot clinics. Unlike adults, brief validated screening tools for children that are appropriate in a busy primary care setting are not available. No validated brief screening tool comparable to the PHQ-9 exists for children ages 0 – 12. In lieu of a validated pediatric assessment tool that is not too lengthy or complex for widespread use in a busy medical practice, clinic staff use developmental "red flags" as a proxy for mental health concerns and, for a smaller subset of children, screen with the Pediatric Symptom Checklist (PSC-17) and the Ages or Stages Questionnaire-Social Emotional (ASQ-SE) tool.

Delivering High Quality Mental Health Services in Primary Care

- During program start-up, from May through December 2008, a total of 77 women and five children received mental health services in the pilot clinics.

- Enrollment occurred at a faster pace early in 2009. As of May 28, caseloads totaling 370 individuals were receiving mental health services, including 37 children and 333 pregnant women and mothers. Overall, clinics were at 90% of their caseload goal by the end of May.

- Among women on current clinic caseloads, 85% received a comprehensive mental health clinical assessment from either MSW staff or psychologists who were part of the primary care team.

- Treatment follow-up with mothers and pregnant women has been strong in 2009; 75% of women on caseload were followed up with repeatedly by phone, clinic visit, or in support groups within four weeks of their enrollment. The average number of follow-up contacts is 3.9 for currently enrolled mothers.

- Of those mothers with sufficient data to track outcomes, 65% showed clinical improvement in depression and 59% in anxiety, as reflected in a five-point or greater change on screening scales. However, these results must be interpreted with caution as only a small number of women have had at least two scores recorded on the PHQ-9 or GAD-7 thus far in 2009.

The chart on the following pages summarizes the program's results in relation to the goals and measures established at its initiation.

Goals	Measures	Results
Clinical Outcomes		
Improve mental health status and functioning	Results of clients' periodic screening over time: PHQ-9; GAD-7 (anxiety); ASQ-SE; DV	PHQ-9 used for 97% of adult clients, but GAD-7 and DV screens underutilized Current clinic caseloads have an average PHQ-9 indicative of major depression All pilot clinics now have access to ASQ-SE for pediatric screening and assessment; no shorter screening tool is available
Improve clients' capacity to reduce risk and address early symptoms of depression	# of clients attending peer support groups or receiving other early intervention strategies during pregnancy or early in parenting years (0–3 years)	22 clients in support groups in May–Dec 2008 27 clients in support groups in Jan–March 2009 Education about depression made available to all pregnant and parenting women in their regular clinic appointments
Process Outcomes		
Improve access to standardized depression screening	# of mothers receiving depression screening at prenatal, postpartum, and well-child visits (for mothers of children ages 0–3)	2,823 (from May 1, 2008–May 28, 2009)
	# of children ages 0–12 who received mental health and/or developmental screening at well-child visits	1,731 screened for developmental red flags 77 identified as at risk of behavioral and/or developmental issues of concern (from May 1, 2008–May 28, 2009)

Goals	Measures	Results
Process Outcomes (Cont'd)		
Improve linkage to specialty mental health services	Increased primary care practice tracking and follow-up assessments for children and families who are referred to mental health specialists for care	Among women on current clinic caseloads: ▪ 85% received comprehensive mental health clinical assessment in primary care ▪ 75% received repeated follow-up by phone, clinic visit, or in support groups within 4 weeks of enrollment ▪ 65% of those screened more than once showed clinical improvement in depression Few successful outside referrals were made for mental health care for low-income women because: ▪ Few women in treatment have severe symptoms that would qualify them to receive specialized mental health services through the RSN ▪ Low-income women only have Medicaid eligibility throughout pregnancy and a few months after delivery As of March 2009, CHI funds allowed pilot clinics to refer children identified through this pilot to Children's Hospital for a one-time psychiatric evaluation. Only 2 referrals have been made.
Assure access	Demographic profile of clients served in pilot projects: Race/Ethnicity; Residence; Age; Insurance Status; Foster Care/Intact Family	For 2,900 clients screened through May 2009: ▪ 77% were below 200% FPL ▪ 54% Latino / Hispanic ▪ 21% Asian / Pacific Islander ▪ 9% Black / African American ▪ 42% limited English-speaking ▪ 4% homeless families

Goals	Measures	Results
Infrastructure Outcomes		
Improve capacity to treat mental health issues in the primary care setting	# (%) of clients receiving treatment and follow-up through integrated behavioral health programs	82 clients received mental health treatment and follow-up from May–Dec 2008 370 clients were on 2009 clinic caseloads as of May 29 (90% of caseload goal)
	# of visits per client	Mean of 3.9 visits or other contacts for mothers Mean of 2.8 visits or other contacts for children Psychiatric consultation conducted for 50% of clients

Challenges

In contrast to successes with pregnant and parenting women, few children have thus far been assessed and engaged in treatment. Among the 37 children on current clinic caseloads, only 22% have received a comprehensive mental health clinical assessment in their primary care setting. Consequently, the pilot project's impact on children is largely through improving the mental health and functional status of their mothers.

There are a number of contributing reasons for inconsistent pediatric follow up, but foremost is the core issue that very few primary care providers or behavioral health staff have experience or training in working with children in regard to possible mental health issues. Clinicians often prefer to refer children out for further assessment and intervention, but there are not sufficient or reliable referral resources among community mental health agencies to meet this need.

To address this issue, the program revised the pilot strategy at the end of 2008 to reprogram CHI funds to support more extensive child psychiatric consultation, evaluation, and technical assistance to support the community health center clinicians in their capacity to evaluate children. These enhancements became available as of February 2009 through a new contract with Children's Hospital Psychiatry and Behavioral Medicine under the direction of UW faculty member Robert Hilt, MD, a pediatrician and psychiatrist.

Lessons Learned

In the first year of this project, eight safety net clinics and maternity support programs demonstrated that they can quickly adapt standardized mental health screening protocols to busy primary care settings for low income mothers. Pilot clinics screened almost 3,000 pregnant and parenting women for depression and mood disorders during the first eleven months. In the same period, over 1,700 children ages 0 – 12 were screened for developmental red flags or other risk factors of behavioral and/or developmental issues.

The success of facilitated peer support groups, intended to decrease mothers' social isolation and broaden parent support networks, varied significantly. Clinics with less diversity in their patient population (for example, clinics with a significant Hispanic majority among patient mothers) were more successful in recruiting and engaging women into group treatment strategies. Pilot sites with more diverse languages and

cultures represented in their clinic population had more difficulty with recruitment. For these reasons, peer support groups may not be a useful treatment strategy in all clinics.

Despite this setback for some sites, the pilot clinics demonstrated that they can efficiently deliver integrated mental health services of high quality within the context of primary care. Overall, clinics were at 90% of their caseload goal by the end of May 2009, and the clinics' performance in providing comprehensive mental health clinical assessment and treatment follow-up with mothers and pregnant women has been strong. Early data suggests positive outcomes among those with sufficient data: over half showed clinical improvement in depression or anxiety, as reflected in a 5-point or greater change on screening scales.

A Success Story — Country Doctor Community Health Centers

Country Doctor Community Health Centers was an early adopter and remains a strong performer among the eight Maternal and Child Behavioral Health pilot clinics. Currently carrying a full caseload of women and children at its two Seattle clinics, Country Doctor shared the following success story achieved through this project:

Maria* is a Spanish-speaking mother to a 1 year old girl and a 6 year old boy. She has been a patient at Country Doctor Clinic for both of her pregnancies and always appeared to staff as a well-groomed, high-functioning mom who is cheerful and friendly. However, in September 2008, Maria completed her first PHQ-9 screening and scored at a level that is indicative of major depression requiring treatment through psychotherapy and/or antidepressants.

Social work staff contacted Maria shortly after the screening and provided an in-person appointment for further clinical assessment, to offer support, and to discuss treatment options. With a referral from the social worker, Maria met with the clinic's behavioral health specialist one week after the assessment. She also consulted with her doctor in early October.

The Country Doctor team created a patient care plan that included a low-dosage of antidepressant medication, regularly scheduled meetings with the behavioral health specialist, and less frequent meetings for medication management. Maria's 6 year old son was also screened for behavioral concerns.

The primary care provider team consulted with a psychiatrist from the UW Department of Psychiatry who reviewed the treatment plan for Maria. The psychiatrist was in frequent contact with the clinic team via phone and email. Consultations were organized through a shared patient registry that captured key information about mental health treatment and utilization.

The social worker also shared information about parenting classes and child development, as Maria requested. Maria was one of the first members to attend Country Doctor's Spanish-speaking peer support group for pregnant and parenting women which began in October 2008. Maria remains a dedicated member of the support group and now brings her younger sister to the group.

While Maria still struggles with depression from time to time, she remains engaged in treatment, is learning important coping techniques, and is caring for her children well. Her most recent scores on the PHQ-9 indicate that her symptoms of depression have largely abated.

**Name has been altered to protect confidentiality.*

Long-term Community Health Outcomes

Evaluation of the CHI allows King County to assess progress toward meeting the vision and goals laid out by the King County Council, as well as to build an evidence base for future interventions. In addition to reporting on the goals originally set for each of the program components, the CHI has been collecting information on additional outcomes to demonstrate its tangible impacts on children and families and make the value of the CHI model clear to a diverse audience.

The long-term community health outcome measures chosen by the Health Innovation and Implementation Committee were selected for their value and relevance, the likely interest of both King County and Washington State decision-makers, and to examine whether the CHI's efforts to enroll and link children with care would result in longer-term impacts.

Getting the data on these outcomes is a work in progress. The status of current data systems and technology for extracting needed information, lack of baseline data, incomplete data sets, and small sample sizes made robust analyses difficult, and in some cases, made it impossible to draw definitive conclusions on the measures.

Studies, such as the research by the Institute of Medicine's Committee on the Consequences of Uninsurance and the Kaiser Commission on Medicaid and the Uninsured, have demonstrated that insurance coverage leads to better access to care for children, which in turn is associated with better health outcomes. Although many factors contribute to improved health status, studies show a direct relationship between public health coverage and improved health. Although the CHI's results in several categories are inconclusive, the research would indicate that the high number of children enrolled through the CHI will likely result in positive health outcomes for the children and the community.

The table below, described more fully in the following pages, shows what was learned to-date about the long-term health outcomes. When available, data for King County and Washington State, or in some cases nationally, provide comparisons.

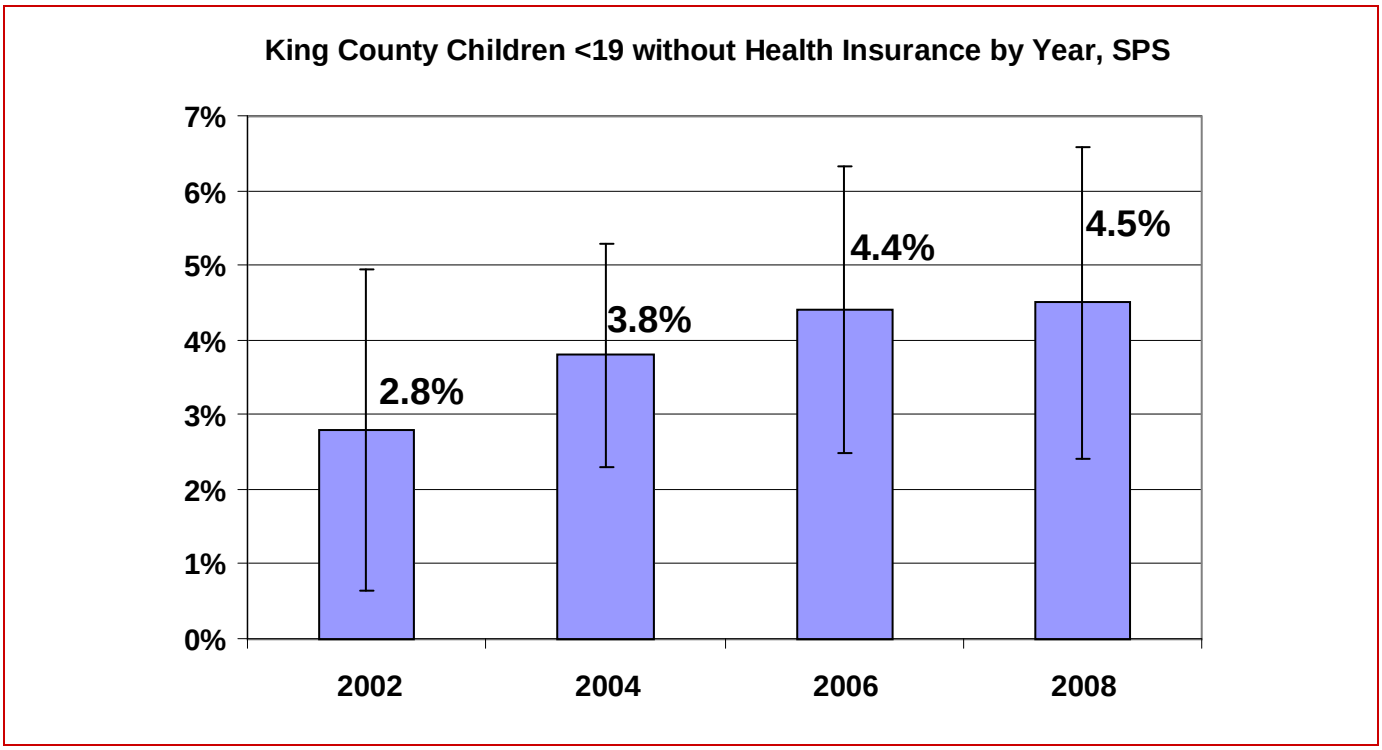
Measure	Available Data
Uninsured children ages 0–18 in King County and Washington State	Data from the WA State Population Survey show that the percentage of uninsured children in King County remains relatively stable, despite significant increases in the percentage of uninsured adults
Immunization rate for CHI-enrolled children	Data available are insufficient to support a robust analysis of immunization rates For the small number of children for whom data were available, recommended immunizations were completed for 59% of children in the 27–36 months age group studied
Well-child visit rate for CHI-enrolled children ages 3–6	Data available are insufficient to support a robust analysis of well-child visit rates For the small number of children ages 3–6 for whom data were available, 41% received a well-child visit
Rate of preventable ER visits for CHI-enrolled children	Data available are insufficient to provide results on this measure

Measure	Available Data
Rate of preventable hospital admissions for CHI-enrolled children	Data available are insufficient to provide results on this measure
Parents' worry about and perception of ease of access to services for CHI-enrolled children	Families with CHI reported more confidence and greater ease in accessing services for their children than families without CHI While reported concern about meeting their children's healthcare needs was not significantly different overall between families with CHI, there was a significant difference among the subset of families with children ages 5–12
Parents' perception of child's health status for CHI-enrolled children	Families with CHI were slightly more likely to rate their children's health higher than a comparison group without CHI
Average number of school days missed due to illness for CHI-enrolled children	Families with CHI were less likely to report that their child missed 5–10 days of school due to illness than those without CHI
Average number of parent work days missed due to child's illness for parents of CHI-enrolled children	Families with CHI were less likely to report that they missed 5–10 days of work due to their child's illness than families without CHI

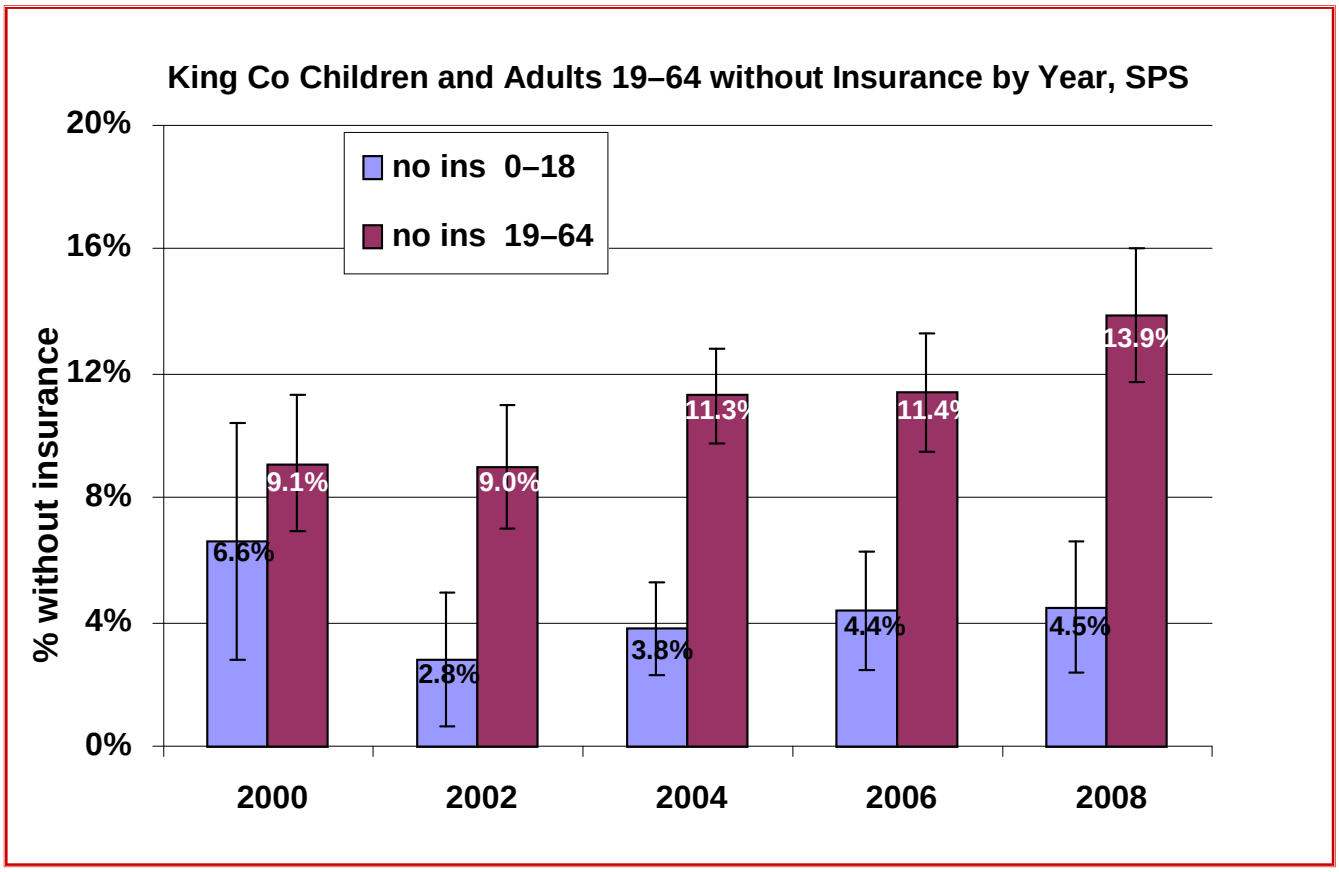
Uninsured Children

The 2008 State Population Survey estimated that 4.5% of King County children ages 0 – 18 were without insurance. The State Population Survey is a telephone survey of a random sample of households in Washington State. In 2008, the survey determined the insurance status of 1,015 King County children, finding that 40 of those children were without insurance.

The chart on the following page shows the estimated percentages of King County's children without insurance between 2002 and 2008, in the years in which the State Population Survey was conducted. The estimated percentages of uninsured children have been rising. However, the brackets beyond the bars—confidence intervals, or the range of possible sampling error in the estimates—show that the increasing percentages are not large enough to be statistically significant. The small numbers of surveyed households and resulting large confidence intervals limit the survey's ability to measure children's insurance rates at the county level, but it is the most up-to-date source of information that is available.



When the 2000 data are included in the sequence (in the chart on the following page) the picture looks somewhat different. The uninsured rate for King County children has not risen significantly, while the rate for adults 19 – 64 rose by 4.8 percentage points from 2000 to 2008—a significant increase. Again, the brackets showing large confidence intervals around the estimates should be noted.



Maintaining stable levels of insurance coverage is a challenge in the current economy. A recent news release from the Washington State Office of the Insurance Commissioner notes that adults and their dependents will continue to lose their health coverage at high rates during 2009—with 95,000 workers projected to lose health insurance due to job loss and 15,000 of their dependents expected to lose their coverage as well.

Immunizations

Using available data and a Comprehensive Clinic Assessment Software Application from the national Centers for Disease Control and Prevention, the table on the next page compares immunization rates for children ages 27 – 36 months for 128 CHI-enrolled children and 76 children in a Medicaid comparison group. Small sample size and the lack of baseline data make rigorous analysis difficult; however, from the available it appears that CHI-enrolled children are slightly less likely to be up-to-date with recommended immunizations for this age group than the Medicaid comparison group, but the results do not indicate a significant difference between the two groups. These results cannot be generalized to all enrolled children given the lack of an adequate sample to assess this measure.

Information from the four safety net clinics that selected immunization rates as an area for quality improvement, however, shows considerable gains made in increasing the rates of up-to-date immunizations for children in the clinic. Although these are not just CHI-enrolled children, but all children seen in these clinics, percentage increases of 6%, 22%, 63%, and 79% for the clinics is a positive indication that more children are completing their recommended immunizations.

Immunization Status	CHI-enrolled Children	CHI Percent	Medicaid Children	Medicaid Percent
Total number of children ages 27–36 months assessed	128		76	
Immunizations completed	75	59%	47	62%
Immunizations not completed	53	41%	29	38%
Children who could get up-to-date in one visit	32	25%	16	21%
Immunizations children need to get up-to-date				
1 immunization	13	10%	11	14%
2 immunizations	6	5%	0	0%
3 immunizations	5	4%	2	3%
4+ immunizations	6	6%	3	4%

Well Child Visits

Data on well-child visits is incomplete, making it impossible to undertake a complete analysis. DSHS claims data on the type of visits children made to a doctor is available for less than half of CHI-enrolled children. However, for the minority of CHI-enrolled children for whom procedure code information is available in the claims data, 41% of the children ages 3 – 6 received preventive services at a well-child visit. Again, these results cannot be generalized to all enrolled children given the lack of an adequate sample to assess this measure.

Family Interviews

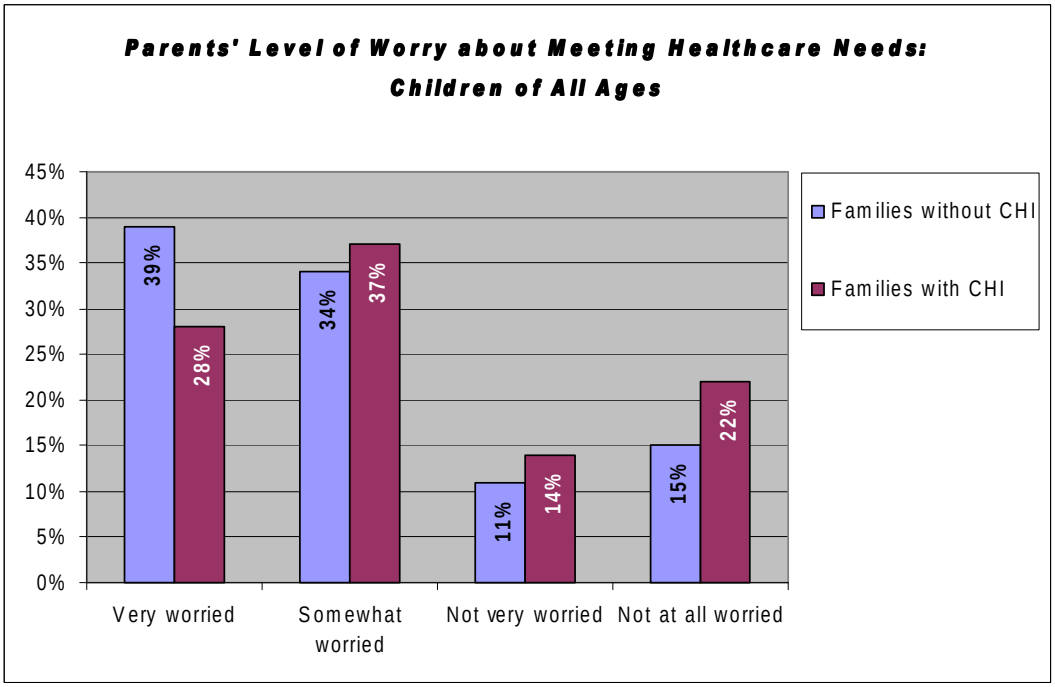
Interviews conducted in 2008 with families enrolled in coverage through the CHI provide information on five of the long-term community health outcomes, including:

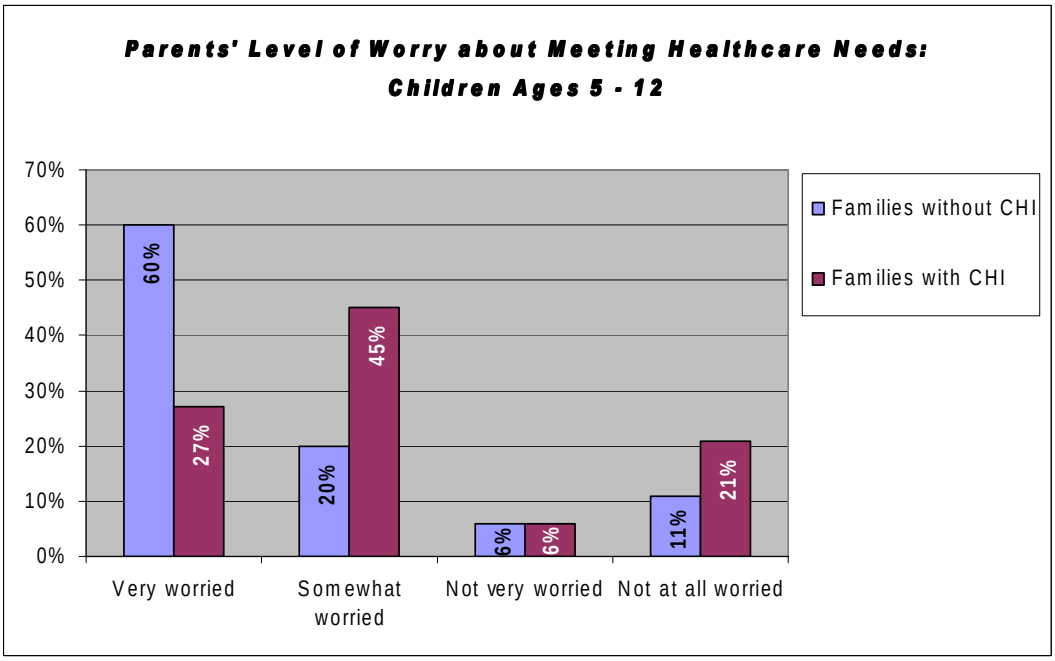
- Parents' level of confidence in their ability to access needed services for their children
- Parents' perceived ease of accessing needed services for their children
- Parents' perception of their children's health status
- Number of school days missed due to illness
- Number of parent work days missed due to child's illness

What follows is a summary of the interviews. The complete report on the family interview results can be found in the appendices.

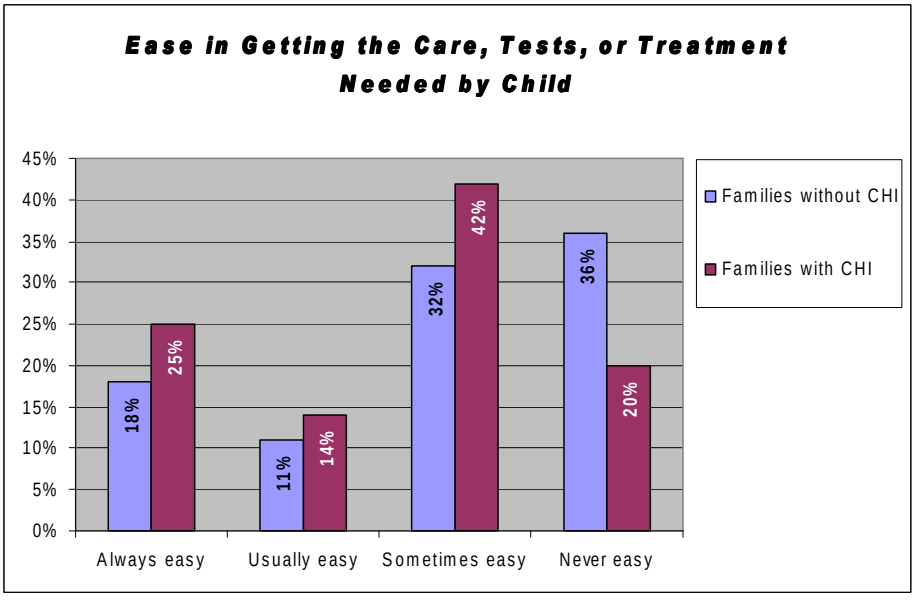
Parents' Worries About and Perception of Ease of Access to Services for CHI Enrolled Children

As part of the interviews with families enrolled in coverage through the CHI, researchers asked parents about their level of worry about meeting their children's healthcare needs. While reported concern about meeting their children's needs was not significantly different overall between families enrolled through CHI for more than one year (shown in the charts on the following page as "Families with CHI") and families enrolled for one month or less and reporting about their experiences before enrollment (shown in the charts on the following page as "Families without CHI"), there was a significant difference among the subset of families with children ages 5 – 12. While 60% of families with children in this age group without CHI reported that they were "very worried" about meeting healthcare needs, only 28% of families with CHI reported that they were "very worried."

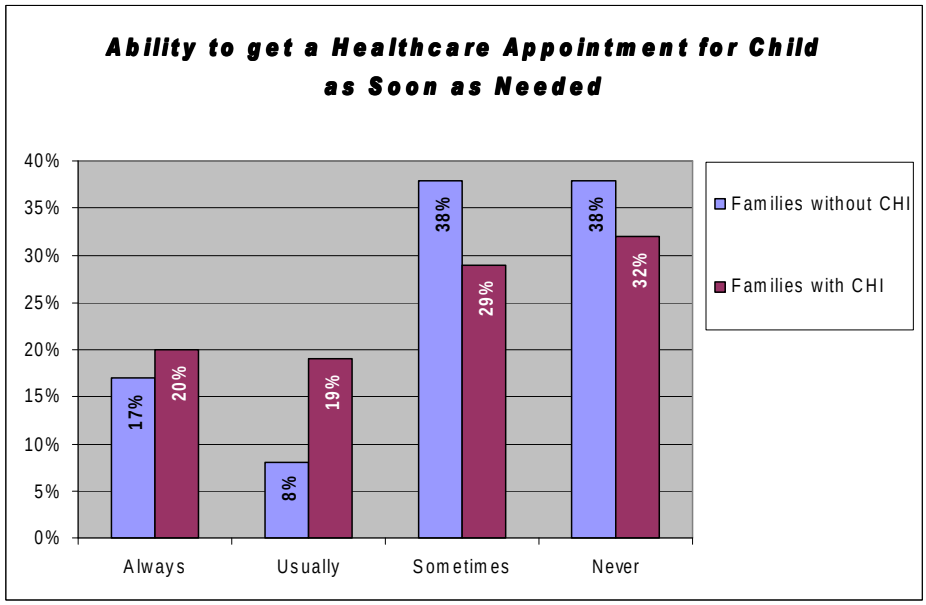




The interviews also found that families with CHI reported greater ease in accessing services than families without CHI. More than one third (36%) of families without CHI reported that it was "never easy" to get the care, tests, or treatment they thought their child needed. This dropped to 20% among families with CHI. Similarly, 30% of families without CHI reported that it "was a problem" to get a satisfactory personal physician or nurse for their child, compared to 11% of families with CHI.



Families with CHI also rated the speed with which they could get an appointment for their children more positively than families without CHI. The chart below shows how interviewed families responded to a question about how frequently they could make an appointment for healthcare as soon as they thought it was needed.



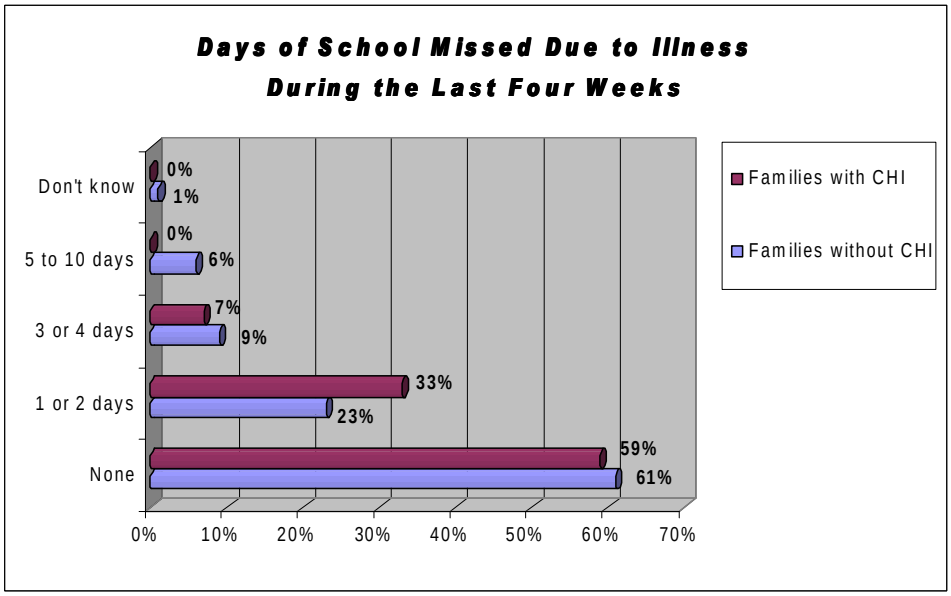
School and Work Days Missed

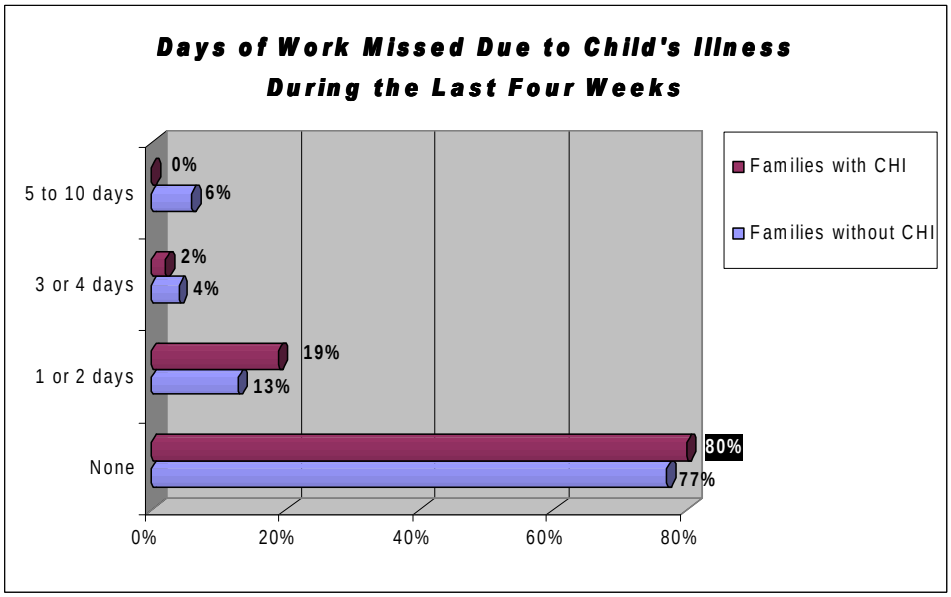
Families with CHI and without CHI reported similar numbers of total school and work absences due to children's illness over the last four weeks. However, a difference surfaced among families missing more than four days of school. None of the families with CHI reported missing more than four days of school or work, but 6% of families without CHI reported that they had missed between five and ten days of school or work in the last four weeks. While this difference represents only a small number of families (four families without CHI), the impact of missing five to ten days of school or work within a four week period can be quite substantial, and therefore is of note.

An evaluation of Santa Clara's Healthy Kids program includes a similar finding, with the percentage of children missing school for three or more days decreasing from 11% for those not connected with Healthy Kids to 5% among those with Healthy Kids. The following table shows school days missed among families in King County, San Mateo County, and Santa Clara County.

County	Percent of Parents Reporting Three or More School Days Missed Due to Illness During the Last Four Weeks	
	Families without CHI/Healthy Kids	Families with CHI/Healthy Kids
King	15%	7%
Los Angeles	Not available	Not available
San Mateo	18%	14%
Santa Clara	11%	5%

The charts below compare the number of days of school and work missed by families with and without CHI.





Challenges

The most challenging aspect of measuring the long-term community health outcomes was the limitations of the available data, which was both difficult to obtain and insufficient for meaningful analysis. The current data systems and technology that are in use made analysis difficult, and in some cases, impossible, hampering efforts to report on tangible impacts for children enrolled in public health coverage through the CHI.

During the selection of the long-term community health outcomes CHI staff and HIIC members discussed the possibility that little change might be observable in the outcomes given the short timeframe for measurement. It became clear, even with the limited data available, that this would be true — that it would take more time for the results to become evident.

Lessons Learned

Early data on the long-term community health measures is encouraging, but inconclusive. While not statistically significant in many categories, the differences in interview responses between families with CHI and families without CHI were positive overall:

- Families with CHI reported more confidence in accessing needed health services for their children
- Families with CHI reported greater ease in accessing needed health services for their children
- None of the interviewed families with CHI reported missing more than four days of school or work due to a child's illness
- The number of CHI families who reported being "very worried" about meeting their children's healthcare needs was lower than non-CHI families and even more pointedly lower among the subset of families with children ages 5 – 12.

Evaluations from other areas in the United States with children's health initiatives similar to the CHI, particularly counties in California with Healthy Kids initiatives, affirm that changes in children's health take time. Outreach, health education, and linkage to care efforts such as the CHI may not show a measurable change in children's overall health until later in the program's implementation.

Problems encountered in tracking and reporting data on the long-term community health outcomes point to the need for an integrated electronic data system. Such a system would provide for better access to more timely and consistent data, allowing local communities and the state to track progress on improvement efforts more quickly. Collaborative work between CHI, Within Reach, and DSHS staff may help move this effort toward fruition.

Conclusions

The CHI is on track to meet or exceed all program goals. Between January 2007 and the end of June 2009, the CHI enrolled 5,785 children which is 89% of the three year enrollment goal of 6,500 children, with six months remaining to reach that target. Enrollment growth for King County surpassed that of the rest of Washington State between March 2007 and February 2009, the most recent time period for which data are available.

Access and Outreach

The data on race and ethnicity of enrolled children and their geographic distribution show that the CHI has been effective in reaching a diverse population, particularly populations with the highest rates of uninsurance, an important step in reducing the disparities associated with unequal access to care. Efforts to create a diverse CHI Access and Outreach staff team may have contributed to this, as has the effort to pursue culturally appropriate and varied strategies to reach and connect with all the populations in need. The CHI made good use of creative strategies to reach target populations that may not otherwise have gained access to health coverage and care, such as the Promotoras Program, which has proven both successful and economical. The interviews with the care coordinators the CHI placed in safety net clinics also documented that they were able to help children and their families overcome language and other barriers that can impede children from accessing preventive care.

Although the data are incomplete and may not accurately portray the extent to which children have completed medical and dental visits, available data show that the CHI has been more successful in getting children to the physician than to the dentist—73% of children enrolled through the CHI through 2008 had at least one visit to a physician, while 40% had at least one visit to a dentist. As further claims data become available, these percentages should increase. The increased health educator focus on oral health in 2009 should also help to narrow the gap between medical and dental visits.

If more complete claims data becomes available in the future it will be possible to better analyze the CHI's goal of establishing an ongoing source of medical and dental care. These data also will enable the CHI to more conclusively establish the rates of preventive care visits.

> "Most Access and Outreach staff started within Public Health and have a direct client services background. They want to do this work and they care deeply. You can't buy passion.
>
> *–Access & Outreach Supervisor*

CHI managers note that investing in robust outreach has made it possible to achieve large gains in enrollment. However, they also have leaned that while this type of one-on-one targeted outreach will likely always be necessary to serve the most difficult to reach populations, if the federal and state systems for enrollment were streamlined and automated, one-on-one assistance could be used only for those with multiple barriers, thus freeing up resources to link children to medical and dental homes and improve their health.

Advocacy and Alignment

Underpinning the results of the Access and Outreach component and the pilot projects are the advocacy and alignment efforts that have helped bring about positive action at the state level to ensure implementation of strategies, policies, and budget priorities to support access to care for children. The joint advocacy efforts and the partnership created with the state have built a strong base of support for the state's implementation of expanded healthcare coverage for low-income families in 2009. Engagement early in the state's process provided an opportunity to share input on development based on King County's experience

with the CHI. The foundation of collaboration between PHSKC staff, child and family advocates, and the state will serve children's health issues well in the future.

Online Enrollment

> "Being 'in the community' makes a huge difference. There is more opportunity to build relationships and people come to trust you. And having places, like the Kent and Federal Way offices, where people can come in and find us, helps establish a continuing presence."
>
> *–Access & Outreach Supervisor*

Despite challenges that delayed full integration of data systems, by the end of December 2008, the Online Enrollment pilot was successful in submitting applications for 663 children from throughout King County, with 66% approved for medical coverage. The pilot's success in convincing the state to accept faxed applications and electronic submissions has made progress toward a more streamlined and accessible application process. The Online Enrollment pilot's screening website has allowed more than 7,000 King County residents in the past 11 months to learn they were likely eligible for health coverage and more than 5,000 likely eligible for Basic Food or WIC.

The pilot is clearly on the correct path for the future, recognizing that greater efficiencies can be gained through electronic means of enrollment, as well as meeting the desires of families for an easier and expedited screening and application submission process. The need for family follow-up to obtain the necessary documents for verification, however, remains an issue for the pilot to grapple with. Of the families who submitted online applications but were denied, 89% lacked required documents.

KC Kids Dental Pilot

The Washington Dental Service conducted the KC Kids Dental Program as a pilot from January through December 2008. The program succeeded in reaching and enrolling 808 children in families between 250% and 300% FPL in dental coverage—80% of the estimated population without dental insurance in this income range. The pilot also succeeded in getting 83% of these children to a dentist for preventive care or restorative treatment with one of the more than 700 participating dental providers in the county. The fact that the majority (70%) of the dental services delivered were preventive is particularly encouraging, both for the long-term dental health of the children and because of the link between preventive dental services and avoided future costs.

This pilot, like Online Enrollment, points to the potential power of technology in the screening process, with over 17,000 KC Kids website hits during 2008 and almost 2,800 individuals completing the interactive form to determine eligibility for the program. In addition, the pilot identified 1,000 children ineligible for the KC Kids Dental Program who were referred to CHI's Access and Outreach.

Maternal and Child Behavioral Health

The Maternal and Child Behavioral Health pilot started slowly but clearly made use of its first year of service delivery to learn what it takes to integrate behavioral health services into primary care settings. Clinics were at 90% of their caseload goal by the end of May 2009 and, of those mothers with sufficient data to track outcomes, 65% showed clinical improvement in depression and 59% in anxiety (as reflected in a five-point or greater change on screening scales).

Primary among the learnings from this pilot is the need for knowledge, capacity, and access to behavioral health-related tools and resources for primary care staff. The availability of a manageable screening tool for mothers helped identify almost 3,000 pregnant and parenting women with depression and mood disorders at the clinics involved in the pilot during the first 11 months of the program. The lack of a validated and

efficient screening tool for children has made it more difficult for clinics involved in the pilots to conduct screenings for children, and the numbers of those ages 0 – 12 who have been screened is just over 1,700.

Finding mental health services for the women and children who screen positive has been difficult. Recognizing the lack of experience and capacity within the clinics, particularly related to children's needs, the pilot's reprogramming of CHI funds helped support more extensive psychiatric consultation, evaluation, and technical assistance. The new contract in February 2009 with Children's Hospital Psychiatry and Behavioral Medicine has begun to address the problem. By the end of May 2009, 99 of the children screening positive were receiving mental health services, as well as 186 of the pregnant women and mothers screening positive—a substantial increase over the figures reported by the clinics at the end of 2008.

Long-term Community Health Outcomes

Some indications of positive impacts are evident in the longer-term measures for the CHI. While most are not statistically significant and other measures remain unchanged, which is unsurprising considering the enormity of the issues they describe, the CHI appears to be headed in the right direction. As the Health Innovation Implementation Committee acknowledged when it selected these measures, accomplishing substantial results on large-scale community-wide measures will be a challenge. The CHI effort reaches a relatively small group of children in the county's population, and therefore, changes in measures such as the rate of uninsured children in King County were unlikely to be evident within three years, which was made even more difficult by the economy and current job losses.

Perhaps of more importance, the learnings gained through the CHI—including the model of service delivery for Access and Outreach, the work undertaken in the Online Enrollment pilot, the early discoveries made in the Maternal and Child Behavioral Health pilot, and the experience of the Oral Health pilot—will be helpful to King County, other local health jurisdictions, and Washington State as a whole.

The CHI presents a model of a successful public and private community collaboration to help families overcome barriers and obtain needed healthcare services. It is important to note the partnerships that developed through the CHI which brought together community organizations committed to expanding coverage for children and improving the healthcare system that serves them. The CHI has been effective in bringing together the right groups of knowledgeable people to achieve success, such as the members of the Health Innovation Implementation Committee and those on the Access and Outreach Committee. The support from Group Health Cooperative, Washington Dental Service, and the many additional organizations that amplified the King County Council funding made it possible for the CHI to expand its strategies and to test models and approaches to service delivery that may become the foundation for an improved healthcare system for children.

APPENDICES

A. Summaries of State Legislation

FINAL BILL REPORT
ESHB 2128

PARTIAL VETO
C 463 L 09
Synopsis as Enacted

Brief Description: Concerning health care coverage for children.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Seaquist and Simpson).

House Committee on Health Care & Wellness
Senate Committee on Health & Long-Term Care
Senate Committee on Ways & Means

Background:

The Department of Social and Health Services (DSHS) is required to provide affordable health coverage for all children living in Washington whose family income is at or below 250 percent of the federal poverty level (in 2008, $53,000 for a family of four). If the Legislature appropriates sufficient funds, the financial eligibility for the program will increase to 300 percent of the federal poverty level (in 2008, $63,600 for a family of four). For children living in families with household income above 300 percent of the federal poverty level, the DSHS is required to offer nonsubsidized health coverage for children beginning on January 1, 2009. The DSHS is also required to offer nonsubsidized health care coverage through the same children's health programs available to children living in families with household incomes below 300 percent of the federal poverty level.

Summary:

The DSHS is required to:

- modify outreach, application, and renewal procedures to increase enrollment and enrollment rates, and renewals and renewal rates;
- use an eligibility card that identifies a child as a participant in the Apple Health for Kids Program;
- develop performance measures that show children in the Apple Health for Kids Program are receiving health care from a medical home and whether the overall health of enrolled children is improving; and
- appoint an Apple Health executive to oversee the Apple Health for Kids program.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

After January 1, 2010, the DSHS will offer families whose household income exceeds 300 percent of the federal poverty level the ability to purchase health insurance for their children without an explicit premium subsidy from the state. The benefit design of the health insurance will be different from the package available to children living in families with household incomes below 300 percent of the federal poverty level.

Votes on Final Passage:

House	68	28	
Senate	30	17	(Senate amended)
House	67	29	(House concurred)

Effective: July 26, 2009

Partial Veto Summary: The Governor vetoed the requirement that the Department of Social and Health Services identify a staff position as the single point of contact and coordination for the Apple Health for Kids program.

FINAL BILL REPORT
HB 1270

C 201 L 09
Synopsis as Enacted

Brief Description: Permitting electronic signatures on applications for public assistance and for benefits administered by the health care authority.

Sponsors: Representatives Green, Cody, Dickerson, Ericksen, Upthegrove, Springer, Roberts and Nelson; by request of Department of Social and Health Services and Health Care Authority.

House Committee on Early Learning & Children's Services
Senate Committee on Health & Long-Term Care

Background:

The Department of Social and Health Services (DSHS) administers a variety of public assistance programs, including Temporary Assistance for Needy Families (TANF), Medicaid, Medicare, and General Assistance for the Unemployable (GAU). The Washington State Health Care Authority (HCA) administers seven health benefit programs, including health care plans for low-income persons, tribal members, and state employees.

The DSHS accepts electronic signatures for the processing of applications in some programs, such as TANF and GAU. The DSHS does not, however, allow electronic signatures for applications under the Medicare or Medicaid programs because federal guidance for administering these programs indicates that states should first have in place a state law expressly allowing for electronic signatures before accepting such signatures for Medicaid and Medicare applications. The HCA allows documentation for eligibility to be submitted via electronic means, to be printed, sent to the applicant, and returned to the agency via the mail. Electronic signatures do not change program eligibility standards and do not alter other information verification processes relating to an applicant's income or residency status. Like physical signatures, electronic signatures are made under penalty of perjury.

Summary:

The DSHS and the HCA are authorized to accept electronic signatures for all programs the agencies administer. Applications must have either a physical signature or an electronic signature. An electronic signature is defined as a signature in electronic form attached to or logically associated with an electronic record to allow a paperless method for signing a

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

document. This may include a sound, symbol, or process attached to or logically associated with the electronic record and executed or adopted by a person with the intent to sign the record.

Votes on Final Passage:

House	97	0
Senate	45	0

Effective: July 26, 2009

B. HIIC Committee Roster

King County Children's Health Initiative Health Innovation Implementation Committee						
Marilyn	Andrews	Supervisor - Community Outreach	Molina Healthcare	marilyn.andrews@molinahealthcare.com	425-424-1100 ext. 144229	
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Bob	Crittenden	Chief Department of Family Medicine	Harborview Medical Center	docbob@u.washington.edu	206-744-9192	
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Patty	Hayes	Executive Director	WithinReach	pattyh@withinreachwa.org	206. 830.5161	
Christina	Hulet	Executive Policy Advisor	Governor's Executive Policy Office, State of Washington	Christina.Hulet@gov.wa.gov	360-902-0660	

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Darlene	O'Neill	Children's Oral Health Program Outreach Coordinator	Delta Dental - Washington Dental Service	doneill @deltadentalwa.com	206-528-7381	
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Mark	Secord	Executive Director	Puget Sound Neighborhood Health Centers	marks@psnhc.org	206-461-6935 ext 127	
Laura	Smith	President and CEO	Washington Dental Service Foundation	lsmith @deltadentalwa.com	206-528-2335	
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Lisa	Zerda	Director - Member Services	Molina Healthcare	lisa.zerda @molinahealthcare.com	425-424-1160	
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Kirsten	Wysen	Policy Analyst	Public Health-Seattle & King County	kirsten.wysen @kingcounty.gov	206-263-8757	
S:\Health Action Plan\CHI\HIIC_Pilot projects -innovative\meetings\CHIHealthInnovRoster					**Last Updated:** 7/8/2008	

C. HIIC Meeting Summaries

Meeting Summary
Thursday, October 23, 2008
Children's Health Initiative
Health Innovation
Implementation Committee

The meeting was held from 10 am to 12 pm in room 116 at 401 Fifth Ave, Seattle, Public Health-Seattle & King County.

Committee Members, Observers and Staff Attending: Abie Castillo, Kay Knox, JoAnn Whited, Karen Merrikin, Claudia St Clair, Lisa Yohalem, Darlene O'Neill, Dorothy Teeter, Judy Clegg, Dawn Smart, Susan Johnson, Lisa Podell, Ann Shields, Rachel Quinn, Susan Thompson, Kirsten Wysen

The meeting commenced with brief introductions followed by a call to order and review of the agenda by HIIC facilitator, Judy Clegg. Clegg refreshed for the group the status of the Measurement & Evaluation Report on the Children's Health Initiative that was delivered to the King Council in early August 2008. To date there have been no questions or clarifications requested by the Executive or Council members regarding the report. All HIIC members were provided with an electronic copy of the report and the appendices. They also were provided with copies of the new Children's Health Initiative brochures, which report on outreach accomplishments over the last year. It was noted that members of the original Children's Health Access Task Force would be interested in these results and CHI staff said they would send them to those original task force members.

Susan Johnson and Karen Merrikin reported on their participation as panelists along with WDSF's Laura Smith and King County Council staff, Carrie Cihak, in a well-attended session at the recent Joint Conference on Health held in Yakima. The panel provided an overview about the beneficial public/private partnership that worked to fund and implement the Children's Health Initiative. In addition, Lisa Podell organized another panel at the joint conference that highlighted successful children's outreach and linkage activities in King, Whatcom and Yakima Counties.

Susan Johnson also was invited to present a CHI update to the Group Health Cooperative Board of Trustees who were very pleased to learn of the successful accomplishments of the CHI and that their investment of $1 million has been returned by the ROI to King County by the number of children enrolled in 2007. The county's $1 million outreach investment in 2008 is estimated to return $4 million in health premiums and health care spending, and in 2009 the return on investment is expected to be $5 million.

<u>Implementation Updates</u>
Advocacy and alignment: Kirsten Wysen, Policy Analyst, gave a brief overview of two studies by the Commonwealth Fund and Robert Wood Johnson. The Commonwealth Fund study showed when Medicaid eligibility periods are shorter (e.g. three months) children have more ambulatory care sensitive hospitalizations than when eligibility periods are longer (12 months). Available at:

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=711359 The RWJ study reported that Washington State has the 8th smallest (best) disparity in infant mortality rates between the highest and lowest quartiles of maternal education levels and the 20th smallest difference in children's health measures between the highest and lowest quartiles of family income. Available at: http://www.rwjf.org/pr/product.jsp?id=35010. Kirsten reviewed the HCCY 2009 legislative agenda which outlines four key priorities: 1) Funding for final phase-in of eligibility expansion up to 300% FPL; 2) Funding for mental health; 3) Funding for health promotion and outreach; and 4) Funding for developmental screens.

Outreach and enrollment: Lisa Podell, Program Manager, provided an update of the county-funded outreach activities in King County. The outreach and enrollment teams are on target to reach the 2008 goal of 2,600 approved applicants—as of the end of September 1,955 new and renewal applications were approved. Many goals for 2008 have already been exceeded. For instance, by the end of September CHI outreach workers had provided culturally appropriate health education and guidance to 3,596 parents and 2,599 community agency and school staff on topics ranging from preventive care, health insurance and linkage to medical and dental homes, which far exceeded the target of 1,500 parents and 2,000 staff. Likewise, Since January 2008, 2,687 children have been provided culturally relevant health education (the 2008 target is 1,200)

With each enrolled child bringing $150/per month into King Count, the expected ROI in terms of managed care premiums and fee-for-service spending for the newly enrolled children will add up to $4 million in 2008 and $5 million in 2009. King County continues to lead all other counties in the state in the rate of enrollment growth.

Lisa also reviewed the reviewed the proposed 2009 SCHIP premiums. For the 200% - 250% FPL the premium would go up to $20 per child with a family cap of $40; for 250% - 300% FPL the proposal is $30 per child with a $60 family cap.

The state allocated $4.4 million in outreach funds for the '07-'09 biennium. Although $4 million has been requested for the '09 –'11 biennium, it is not likely to be funded considering the projected state deficit. Although the state is expected to move forward in January, 2009, to extend coverage to children up to 300% FPL, as called for in the Cover All Kids law, the state is not yet ready to require linkage activities and data share agreements in contracts with other counties.

Pilot Projects:
Online Enrollment: Kay Knox and and JoAnn Whited from Within Reach were present to brief committee members on the progress of online enrollment. Within Reach is one step closer to e-submissions (the electronic submission of application data to DSHS)! ParentHelp123 users can now submit an application online through the www.ParentHelp123.org website. Once received, Within Reach will follow through with faxing applications to DSHS. Website data from August 22 to September 30 showed that 80%, or 815 users elected to send their application online. The e-applications were for a variety of programs: 320 children's medical, 60 pregnancy medical, 266 BHP and 169 for food. Additional new website developments are a Spanish language Benefit Finder that is now fully operational and a new 'Professionals Section' that offers a resource took kit for professionals and sets the stage for the "super-user" version anticipated in the fall of 2009. Next steps are the development of

the "super-user" version, implementation of e-faxing by the end of 2008, e-submission to the state by summer 2009 and as mentioned, the launching of the "super user" version in fall 2009.

Mental Health Pilot: Anne Shields from Public Health Seattle-King County provided an update on the Mental Health pilot project. The pilot is working with five agencies at nine clinic sites. Early results indicate that partnering clinics are doing well with screening activities but are finding it challenging to treat clients, due to provider inexperience, and poor access to mental health providers clients into treatment. This should improve as care coordinator and provider training continue and psychiatric consultation services are gelled.

KC Kids Dental Program: Darlene O'Neill from WDS reports that as of the end of September 664 kids have been enrolled in the KC Kids Dental program and 72% of them have accessed care through 356 dental providers in King County. WDS sends out a monthly letter to enrollees to encourage them to make dental appointments and reminding them that KC Kids is a time-limited program. WDS is working with PHSKC on a plan to transition eligible KC Kids enrollees to state-funded programs as of Jan. 1, 2009 when the state extends medical and dental coverage to families up to 300% FPL. An information packet will be mailed to all enrollee households in November providing them with information on the *Washington Apple Health for Kids* program and contact information to the CHI outreach teams. Based on experience over the past year it is anticipated that some of the KC Kids enrollees will not be eligible for SCHIP because they have medical coverage through a parent. SCHIP does not provide wrap around dental coverage for these children, a point which has been brought to the attention of State officials by HIIC committee members. However, a federal waiver or legislation is needed to change this policy.

Committee members asked if WDS was working with the state to explore the possibility of implementing a Michigan-type model in Washington where WDS would administer Medicaid dental services in some rural Washington counties. Over the past year WDS has met with the state several times to discuss this issue. In the 2009 legislative session a three-year pilot will be proposed by WSDA and a coalition of health and dental advocates. The proposal is based on Michigan's successful model and would cover one-third of Washington State's Medicaid eligible children in 21 counties where dental Medicaid utilization is as low as 10 percent.

Committee members also asked if the KC Kids dental providers from the WDS PPO network would continue to provide dental services to children who transitioned to Medicaid programs. Reimbursement for the KC Kids program is higher then what Medicaid offers. This could be an opportunity for WDS to do some advocacy among their PPO providers to receive ABCD training in order to increase Medicaid reimbursement for services.

Progress on Measures for 2009
The IRB for the CHI telephone evaluation survey was waived, which was great news. The survey tool is ready and the Gilmore Research group will start conducting the surveys in November. Data should be available by January.

2009 Budget and Sustainability
In 2009 the county-funded, highly successful CHI outreach and linkage efforts will continue. However, it is the last year the county will support this work. There was discussion regarding what other options for sustainable funding could be identified.
One possible source of additional funding is private dollars that were set aside for financial sponsorship to reduce the burden of premium expense for SCHIP families. Given the reasonable SCHIP premiums being proposed this funding will not be necessary and funds could be re-programmed to support outreach and linkage work in 2010.

CHI staff reported that there is significant ROI for the outreach and linkage work. Every child successfully enrolled brings state money to King County. The $150 per child per month paid to participating health plans represents millions of dollars to health plans and our local economy each year. The linkage to services and connections to a medical home reduces unnecessary medical costs. The innovative CHI model of outreach and linkage also offers important learnings for the State's outreach efforts with benefits to the rest of the state as well.

Further discussion and decisions about a sustainable outreach funding level going forward and possible funding sources will be a focus of the December HIIC meeting.

Update on Public Health Funding
Susan Johnson provided committee members with an update on Public Health funding, the proposed cuts and the need to fund sustainable public health funding. In short, for at least the past decade, since the motor vehicle excise tax (MVET) funding source for public health was removed, public health has been without a long term stable source of state funding. At the local level also, public health has no capacity to generate a source of flexible funding that can grow over time with inflation. This creates a combined structural problem which will be the focus of state-wide public health efforts this coming legislative session. For 2009, PH-SKC is looking at long term reductions of $11m with an additional $8m of cuts in a "lifeboat" awaiting assistance for a state legislative solution.

Next Steps
The focus of the next HIIC meeting will be advocacy work for the 2009 legislative session and continued discussion and decisions regarding the 2009 CHI budget. The next HIIC meeting will be in January 2009.

Meeting Summary
Thursday, January 15, 2009
Children's Health Initiative
Health Innovation
Implementation Committee

The meeting was held from 10 am to 12:30 pm in room 117 at 401 Fifth Ave, Seattle, Public Health-Seattle & King County.

Committee Members, Observers and Staff Attending: Abie Castillo, JoAnn Whited, Patty Hayes, Sharon Beaudoin, Lan Nguyen, Claudia Sanders, Karen Merrikin, Lisa Yohalem, Darlene O'Neill, Peggy Wanta, Tom Byers, Dawn Smart, Susan Johnson, Lisa Podell, Ann Shields, Susan Thompson, Kirsten Wysen, Susan Kinne

The meeting commenced with brief introductions, acknowledgements that personal challenges were being faced by Dawn Smart and Judy Clegg, and followed with a call to order and review of the agenda by Susan Johnson who facilitated the meeting.

Kirsten Wysen gave the group an overview of the SCHIP renewal process in Washington, DC as well as elements of the Governor's proposed budget as relate to the HCCY agenda, CHI and advocacy strategies. Handouts were provided on these items. Discussion ensued around the effect delays to expansion would have on the dental program pilot ending and the group's sense that outreach was needed more than even now due to the increasing numbers of residents losing jobs and health coverage.

It was in the context of this changing landscape at the state level that the revised budget was presented for discussion and consideration. Understanding that the Outreach committee would take a longer view of sustainability for CHI outreach, the immediate suggestion presented in the revised budget was to redistribute funds previously budgeted for premium sponsorship to outreach and to reapportion the evaluation budget given the new work on the measures underway in 2009. Following brief discussion concerning the continued commitment of the County to live up to its pledge of $1m for outreach in 2009, a motion to accept the revised budget was made by Karen Merrikin, seconded by Tom Byers and unanimously accepted.

Dawn Hanson Smart gave an update on the Measures being collected for 2009 and stated that evaluation of the Family Survey data is underway with preliminary analysis showing positive elements. Review of all survey elements likely at the next HIIC meeting.

Susan Kinne, epidemiologist with PH-SKC, shared the results of her evaluation of the first measure; uninsured children aged 0–18 in King County, using the newly released 2008 WA State Population Survey. One finding is that due to the intensive enrollment efforts of the CHI, children are holding even while adult health insurance coverage rates are decreasing. A copy of her work showing this was distributed.

Implementation Updates

Advocacy and alignment: Kirsten Wysen, Policy Analyst, had earlier given this update covering the SCHIP reauthorization, Apple Health possible contingencies and some discussion regarding possible federal stimulus bill effects.

Outreach and enrollment: Lisa Podell, Program Manager, provided an update of the county-funded outreach activities in King County. Two handouts were distributed; 2008 year-to-date outcomes and objectives and 2008 CHI children enrolled. All objectives were met or exceeded in 2008, notably 3,043 children were enrolled in coverage. The target was 2,600.

Pilot Projects:

Mental Health Pilot: Anne Shields, from Public Health-Seattle & King County, provided an update on the Mental Health pilot project.

The eight clinics and maternity support programs in the pilot program screened over 1,500 children ages 0-12 during the first six months of implementation. 359 (23% of children screened) were positive for mental health concerns. As relatively few primary care providers and MSWs at pilot clinics have direct experience with mental health screening and assessment in children, funding strategies were revised at the end of 2008 to reprogram CHI funds to contract for psychiatric consultation and technical assistance through Children's Hospital Psychiatry and Behavioral Medicine Department in 2009. Consultation services for children will be provided by and under the direction of UW faculty member, Robert Hilt, MD, a pediatrician and psychiatrist.

Dr. Hilt also directs a child mental health consultation program called the Partnership Access Line (PAL) for DSHS providers.[2] PAL provides rapid telephone access to child psychiatrists, free practical care guides and patient handouts, and assistance finding psychiatric resources.

KC Kids Dental Program: Darlene O'Neill from WDS reports that as of the end of December 2008, 808 kids out of 1,000 estimated possible have been enrolled in the KC Kids Dental program and 83% of them have accessed care. Approximately $537,000 has been spent on treatment claims received for 6 months over the year long program and although total cost of restorative treatment was higher, there were 911 preventive encounters compared to 521 for restorative care. As planned, the program ended on December 31, 2008. In November each enrollee family received a letter discussing the end of the program and providing information on enrolling in the state SCHIP program. WDS has plans to produce a "mini magazine" of lessons learned. When this is available we will distribute to the committee.

Online Enrollment: JoAnn Whited from Within Reach gave an update on progress to date. In the last five months, over 5,000 people have used the Benefit Finder feature of the ParentHelp123.org website to find out what public benefits they may be eligible for. About 2,000 applications were submitted for children's medical coverage.

[2] For more information about PAL, see www.PALforkids.org for the PAL handbook and recommendations on primary care principles for addressing child mental health issues.

WithinReach staff are working on establishing a secure electronic submission process with DSHS. WithinReach currently uses electronic faxes to send in applications, which cuts down on the use of paper, but still requires data entry from the applicant and re-keying the same information by DSHS staff. Patty Hayes, JoAnn Whited, Tony Lee (Common Ground), Annique Lennon (the Children's Alliance) and Kirsten Wysen (PHSKC) met with DSHS staff in December to plan for testing and implementing the electronic submission process. The HIIC will be kept informed on progress in establishing electronic data transfers from WithinReach to DSHS.

The passage of the electronic signature bill this legislative session will make electronic applications more streamlined, although paper citizenship and income documentation will still be needed to determine eligibility.

ParentHelp123.org users have shown they prefer using an electronic method to submit their applications, rather than printing and mailing them in on their own. When asked at the end of the ParentHelp123.org application whether they wanted WithinReach to e-fax their application in or print and mail, 80% chose to have WithinReach submit their application via e-fax. WithinReach also is developing pilot approaches to complete annual application renewals using the cell phone numbers and email addresses. DSHS does not routinely use these contact methods for renewals, relying instead on mailings.

The meeting adjourned just after Noon with the next meeting likely to be in April, 2009.

Meeting Summary
Thursday, April 9, 2009
Children's Health Initiative
Health Innovation
Implementation Committee

The meeting was held from 10 am to 12:00 pm in room 117 at 401 Fifth Ave, Seattle, Public Health-Seattle & King County.

Committee Members, Observers and Staff Attending: Abie Castillo, JoAnn Whited, Patty Hayes, Karen Merrikin, Lisa Yohalem, Tom Byers, Marilyn Andrews, Judy Clegg, Dawn Hanson Smart, Susan Johnson, Lisa Podell, Ann Shields, Susan Thompson, Kirsten Wysen.

The meeting commenced with brief introductions and followed with a call to order and review of the agenda by Judy Clegg who facilitated the meeting.

Susan Thompson gave a review of the HIIC budget highlighting that due to lower than projected overhead expenses there is $29,269 in unspent 2008 funds. It is anticipated there will also be unspent funds in 2009 which are conservatively estimated at $20,000. It was proposed to reprogram $35,000 of these funds: $25,000 to the Cedar River Group (CRG), and $10,000 to Maternal and Child Behavioral Health pilot. The CRG has been working beyond the scope of their current contract to assure complete implementation of SB 2128 especially those parts that directly relate to the goals and objectives of the Children's Health Initiative. The additional $10,000 of funding for the Maternal and Behavioral Health pilot would offset higher than anticipated need and expenses for children's psychiatric consultation. The committee approved this reallocation of funding.

Dawn Hanson Smart took us through the Measurement and Evaluation February 2009 Status Report by combining the updates of activities with information contained within the report:

<u>Big Picture Measures</u>
While data on many of these measures is not yet available, a key source of information about the percentages of uninsured children in King County did become available in 2008. The 2008 Washington State Population Survey shows that the percentage of uninsured children in King County remained relatively stable, despite significant increase in uninsured adults and despite the economic recession.

Advocacy and Alignment

Regarding Advocacy, Kirsten Wysen brought to the committee's attention that the Kaiser Foundation Commission on Medicaid and the Uninsured requested CHI participation in a briefing to examine the state of children's coverage and discuss the potential impact of SCHIP reauthorization, broader health reform efforts and the ongoing recession. Susan Johnson participated in the briefing and shared the great work that is going on with outreach in Washington State stressing the continuum of outreach, the need for linkage to a medical and dental home and the ultimate desire to be able to deem all children as covered and focus on getting them the services they need at the time they need them.

The SCHIP reauthorization bill, CHIPRA passed April 1, and guidance as to implementation is being released section by section. There should be more match money available. States that have at least 5 of 8 streamlining measures in place will be eligible for bonus funding. Washington currently has either 4 or 5 depending on interpretation of our Employee Subsidy program, and is taking steps to implement express lane eligibility.

Senator Murray has introduced a new HCAP replacement in the Senate. The new program is called Community Coalitions for Access and Quality Improvement (CACQI) The House and Senate are currently seeking additional sponsors.

There is a lot of speculation, but less is known about the implementation logistics of funds available through the federal stimulus package. Kirsten is working with a group at the health department to learn more about stimulus funding and position the department for stimulus opportunities as they arise. The public health department qualifies for some new health center funding, since it is a HRSA health center grantee for the Health Care for the Homeless program. The department is waiting for additional information about the new CDC Prevention and Wellness funding opportunities, NIH grants and health information technology funds.

Federal CHIP outreach grants will be offered through a RFA process to states, local organizations, county governments, faith-based groups and others. Priority will be given to groups who have experience and skills in connecting with communities that are often uninsured, including rural residents, populations of color and those who don't speak English. The HIIC group discussed the advantage of forming a statewide coalition to respond to the RFA. The time to do this planning work is now in advance of the release of the RFA which is expected in the fall. Several HIIC members and staff (Abie, Tom, Patty, Lan, Kirsten, Lisa and Karen) formed a workgroup to further explore forming a statewide coalition. The group decided to take preliminary steps to explore a coalition approach and is currently gathering

data on uninsured children statewide and best practices in outreach that have been learned nationally and over time in Washington state.

Access and Outreach

Lisa Podell, Program Manager, provided an update of the county-funded outreach activities in King County. Handouts were distributed for all of 2008 date and the first quarter of 2009. All objectives were met or exceeded in 2008. Notably 3,043 children were enrolled in coverage (the target was 2,600) and the program is on track to meet 2009 objectives. The gap between approved and submitted applications that appeared to be widening in early 2009 has narrowed back to the usual ~80% approval rate in the first 5 months of 2009. Other good news is that CHI enrollees are getting to doctors (89%) and dentists (60%). The data share agreement is working inconsistently; there is a 12 to 18 month delay in getting the data which often varies in volume and quality.

Lisa also presented data on the number of children enrolled and linked to services by CHI teams compared to contracted CBO staff which reveals significantly higher productivity by the CHI teams. There are many possible reasons for this including the expertise and years of experience of CHI staff in doing outreach, and the strong supervision component built into the CHI outreach team model as compared to CBO staff.

Maternal and Child Behavioral Health Pilot

Anne Shields, from Public Health-Seattle & King County, provided an update on the Mental Health pilot project. A separate evaluation will be funded through the levy and will be released by the project at the end of April. The health centers receiving funding have shown a lot of variation in their performance measures, which supports the need to invest in improvements in the delivery of integrated medical and mental health care. To dig deeper into this variation, the mental health pilot project convened two focus groups of medical providers this spring to identify how to improve access to mental health services and how to improve systems of care. The mental health pilot project continues to use quality improvement techniques (plan-do-study-act cycles) and greater transparency around performance measures to create learning opportunities about how to improve access.

Oral Health Pilot

Susan Thompson handed out a report just completed by on the KC Kids Dental program. The report outlines the implementation process for the KC Kids program and final program outcomes. The report will be distributed to CHI partners, WDS board and other stakeholders. One learning from the KC Kids program was the lack of availability of dental wrap around services for SCHIP-eligible children who have private medical coverage. This issue has been

addressed at the federal level through CHIPRA and now dental wrap around services are available to SCHIP-eligible children.

Online Enrollment Pilot

Patty Hayes and JoAnn Whited from Within Reach gave an update on progress to date. Within Reach staff continue to have meetings with DSHS to facilitate the establishment of a secure electronic submission process, but progress is slow. From January to March 2009, over 15,000 users statewide have visited www.ParentHelp123.org. Users start with the BenefitFinder section, which provides them with information about what programs they are likely eligible for after they answer a few screening questions. 10,000 users statewide, including 3,200 in King County, were found likely eligible for health coverage and about 7,400 (2,400 in King County) were for food assistance. Two thirds of these users proceed to the application part of the ParentHelp website. The average time to complete both the screening and application process is 15 minutes.

JoAnn reported that WithinReach has collected information on all the families that have been referred to medical coverage and food assistance in 2008. 30,000 families used their website and 20,000 additional families used the WithinReach call center to obtain health coverage; and 16,000 families used the ParentHelp123.org website to get connected to food assistance and 97,000 used their call center to do so. All in all, WithinReach as an organization connected 163,000 families to health and food benefits in 2008, which was worth $156 million in services.

Tom Byers provided the HIIC group with an Olympia update:

- There is a 0.3 % increase in sales tax to fund health items currently being proposed. This would require a public vote for approval. The Referendum would provide funding for public health, the Basic Health Plan and hospitals.
- Apple Health HB 2128 reiterates the call for coverage for all kids, a single administrator for the program a unique ID card and specifics regarding measurement of outcomes that align nicely with the work of the CHI.
- The plan to implement a buy-in program for families earning over 300% FPL is more controversial—the Governor took it out of the budget and the House has put it back in.
- Despite strong support in Olympia for Apple Health, it is unlikely to emerge intact from this legislative session due to the size of the state budget deficit. Decreased reimbursement rates to providers and hospitals may mean more access issues for those enrolled. There may be more and more areas of the state where finding a provider to see an Apple Health child may be next to impossible.
- The immunization program for children was cut significantly in the state budget.

Tom also reported he has discussed with Rep. Larry Seaquist integrating measures into state performance indicators on the negative impact of the current recession for families and child health. United Way recently posted data on indicators of the recession, and in January 2009 George Washington School of Public Health and Health Services released a document titled, *Examining the Health Consequences of the 2008-09 Recession.* These documents will be reviewed by a HIIC working group (Kirsten, Tom, Dawn and Susan T) for the purpose of developing indicators to measure the impact on families and health due to the recession to inform legislators and other interested parties.

Next Steps

A sub-group of HIIC members and staff will meet to coordinate the formation of a possible statewide consortium to respond to the forthcoming CMS federal outreach grants that we think will seek to push out federal outreach funding into local communities. A working group of consortium partners representing WithinReach, Community Health Plan, Public Health – Seattle & King County, Communities Connect, Health Coalition for Children and Youth will get this effort started.

A sub-group of HIIC members and staff will meet to discuss the development of indicators to measure the impact of the recession on families and health.

A proposed date in May for a brown bag lunch will be sent out to HIIC members who are interested in hearing a report from the CHI family survey.

The meeting adjourned just after noon with the next meeting likely to be in July 2009 to review and discuss the annual report due to the King County Council in August 2009.

Meeting Summary
Thursday, May 21, 2009
Children's Health Initiative
Health Innovation Implementation Committee
Family Survey Results Review

The meeting was held from 10:00 am to 12:00 pm in room 117 at the Chinook Building, 401 Fifth Ave, Seattle, Public Health-Seattle & King County.

Committee Members, Observers and Staff Attending:
Abie Castillo, JoAnn Whited, Ben Danielson, Lan Nguyen, Marilyn Andrews, Caren Goldenberg, Charissa Fotinos, Judy Clegg, Dawn Hanson Smart, Rachel Quinn, Lisa Podell, Susan Thompson, Kirsten Wysen.

The meeting started with a quick round of introductions and followed with a call to order and review of the agenda by Judy Clegg who facilitated the meeting. Dawn Smart walked the Committee through highlights of the findings of the Family Interviews with Children's Health Initiative (CHI) enrollees.

Dawn reviewed the methodology behind the Family Interview study. Gilmore Research conducted interviews with families enrolled in Medicaid or CHIP through the CHI. During November and December 2008, Gilmore completed 153 family interviews. Families were divided into two groups—established families that had enrolled a year before the interview, and those who were new to the program, enrolling within the last month. Newly-enrolled families (called "families without CHI" in the report) served as a comparison group for more established families (called "families with CHI").

Following the description of the methodology, Dawn went over the characteristics of the interviewed family, which are on pages 9 and 10 of the report. Interviewed families had children ranging from under age 5 to over age 18 with the predominant age category ages 5 -12 representing 44% of interviewed families. A second notable point is that the vast majority of interviewed families were Hispanic/Latino (78%). The Steering Committee members discussed the demographics of the phone interview participants, noting that 96% were people of color (78% Hispanic, 11% Asian, 4% black and 3% other).

Interview questions measured changes in:

- Parents' level of confidence in their ability to access needed services for their children,

- Parents' perceived ease of accessing needed services for their children,
- Parents' perception of their children's health status,
- Number of school days missed due to illness and
- Number of parent work days missed due to child's illness.

In general, results from the family interviews showed:

- Families with CHI reported more confidence in accessing needed health services for their children
- Families with CHI reported greater ease in accessing needed health services for their children
- None of the interviewed families with CHI reported missing more than four days of school or work due to a child's illness.

CHI families who reported being "very worried" about meeting their children's healthcare needs were decreased when compared to non-CHI families (28% and 39% respectively). However, this was amplified among the subset of families with children ages 5-12. Sixty percent of non-CHI families in this age group reported being very worried compared to only 27% of CHI families.

Dawn discussed the "under 5" effect noted in the survey: families with children under age 5 in both the "with CHI" and "without CHI" groups gave responses that were different from families with older children. In general, these families were more confident in accessing services and had a more positive outlook on their experiences obtaining healthcare for their children. For example, across both groups a full half of families with children under age 5 were "very confident" that they would be able to get healthcare if their child needed it, compared to 28% of families with children ages 5-12. The meeting group discussed possible reasons for this including the possibility that families with young children may have more frequent encounters with the health system that influences their sense of confidence and attitude.

The family interviews did not find a difference between the families with and without CHI in parents' perception of their children's health status. The group discussed why this measure did not show an effect and concluded that outreach, health education and linkage to care efforts may not show an improved health effect so early in the program's progress. Several California Counties' evaluations with similar designs were completed in the third of fourth year of the program. In addition, the Gilmore family interview study had a relatively small sample size and the limitation of a survey design makes it impossible to flesh out how a parent ranks categories such as "very good" and "good" and why they select one over the other.

Other positive findings included:

- There was a 50% lower level of missed school days for CHI versus non-CHI children. Overall 7% of CHI children missed three of more days of school in the prior month, while 15% of non-CHI children did so.
- None of the families with CHI reported missing more than four days of school or work in the past month due to a child's illness, whereas 6% of those without CHI reported that they had missed between five and ten days of school or work in the last four weeks.

There was not a significant difference in the percentage of parents missing work days due to a child's illness between the CHI and non-CHI families.

Lisa Podell congratulated Ben Danielson on the very moving speech he gave to a group of Black Ministers at an event the prior week where he framed health disparities as a civil rights issue, and she thanked him for mentioning the Children's Health Initiative as one example of an approach that is working against health disparities. Ben said he appreciated having the evaluation data and program numbers about the CHI to use in his work.

Dawn and Judy wrapped up the meeting at noon and promised to finalize the Family Interview study the next week. The next HIIC Committee meeting is scheduled for Thursday, July 16, 2009 to review and discuss the annual report due to the King County Council in August 2009.

D. Access & Outreach Committee Roster

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Susan	Johnson	Director, King County Health Action Plan	Public Health - Seattle & King County	susan.johnson @kingcounty.gov	206-263-8684

E. Report on Family Interviews — April 2009

Executive Summary

The King County Children's Health Initiative (CHI) is a public/private partnership designed to improve low-income families' ability to enroll in federal and state health insurance programs for which they are eligible and to ensure that children obtain appropriate preventive medical, dental, and behavioral healthcare. CHI strategies include outreach to families and services to help link them to an ongoing source of healthcare. Three pilot projects explore new ways to increase access to healthcare, including dental and mental health care. The CHI also incorporates advocacy work to sustain the effort into the future.

Ultimately, CHI strategies are intended to have long-term impacts on children's health, quality of life, and avoided costs for communities in King County, as the preventive care made available not only improves children's health and lowers costs from avoidable emergency room visits and hospitalizations, but can also reduce the number of school and work days that families miss due to a child's illness.

To begin to assess its progress toward these long-term goals, in 2008, its second year, the CHI hired Gilmore Research to conduct interviews with families enrolled in public health insurance coverage through the CHI. During November and December of 2008, Gilmore completed 153 family interviews. Families were divided into two groups for the interviews—established families in the program that had enrolled a year before the interview, and those that were new to the program, enrolling within the last month. Newly-enrolled families (called "families without CHI" in this report) served as a comparison group for more established families (called "families with CHI") who had sufficient time to seek medical and dental care for their children.

Specifically, interview questions measured changes in:

- Parents' level of confidence in their ability to access needed services for their children
- Parents' perceived ease of accessing needed services for their children
- Parents' perception of their children's health status
- Number of school days missed due to illness
- Number of parent work days missed due to child's illness

Data across some demographic categories, such as differences in responses based on ethnicity, did not represent a sufficient number of families to make meaningful comparisons. However, differences in responses based on whether the family was newly enrolled or established in the program surfaced in several categories.

Data from the family interviews related to these measures show:

- Families with CHI reported greater ease in accessing needed health services for their children
- Families with CHI reported more confidence in accessing needed health services for their children
- None of the interviewed families with CHI reported missing more than four days of school or work due to a child's illness

Findings from the family interviews are encouraging. The CHI's evaluation will supplement the information obtained from the interviews and continue to track progress in 2009 with a number of additional measures. The new measures include well-child visit rates, immunization rates, and rates of preventable emergency room visits and hospital admissions for CHI enrolled children.

Background

The vision and mission of the CHI, adopted by the King County Council in 2007, is to improve the access to care and the health of children in King County. The following vision and mission statement guides CHI's advocacy, outreach, and health innovation pilot projects:

> King County's vision is for every child in King County to achieve optimal health and grow into a healthy adult. Recognizing that regular access to healthcare is necessary to achieving optimal health, the mission of the county's Children's Health Initiative is to create conditions under which children have consistent access to comprehensive, preventive-focused primary healthcare prioritizing those activities which will have the most significant impact on health or reduction in health disparities.

Partners

The CHI is a collaborative initiative of the King County Council, the King County Executive, Public Health—Seattle & King County (PHSKC), the State of Washington, Group Health Cooperative, the Washington Dental Service, and a diverse range of private funders and community-based organizations. The breadth of CHI's financial support and the expertise of its service delivery and advocacy partners are testimony to the importance the community places on ensuring access to timely preventive services and medical, dental, and behavioral healthcare for low-income children and their families.

Program Overview

The CHI is a multi-faceted effort that helps children and their families overcome barriers to obtaining needed healthcare services through a set of state-of-the-art programs.

- The Advocacy and Alignment Component works collaboratively with state and federal policymakers to ensure achievement of full implementation of the Cover All Kids law. Working with other child and family advocates, CHI staff work for the implementation of policies and systems that improve the health of low-income families.

- The Access and Outreach Component, which the family interview survey evaluates, reaches out to identify and enroll children in public health insurance programs for which they are eligible, employs trusted messengers from the community to deliver information about the value of early prevention and insurance, links families and children to a regular source of medical and dental care, and encourages quality integrated service delivery within clinics by utilizing care coordinators.

- The Online Enrollment Pilot Project builds user-friendly web access for parents to easily enroll their children in public health insurance and other basic needs programs through use of WithinReach's ParentHelp123 system.

- The Behavioral Health Integration Pilot Project includes a diverse array of services, interpreted into multiple languages, to provide an integrated set of mental health and medical care services for children and their families.

- The KC Kids Dental Pilot Project was implemented by the Washington Dental Service and served as a demonstration for the state's expansion of dental coverage up to 300% of the Federal Poverty Level effective January, 2009.

Long-Term Impacts

The strategies employed through the CHI are intended to have long-term impacts on children's health, families' quality of life, and avoided costs for communities in King County. The preventive care made available to children not only improves their health, but also is aimed at lowering their use, and therefore, the costs of emergency rooms and hospitals. Preventive care is believed to reduce the number of school days these children miss and the work days that families miss due to a child's illness.

In early 2008, the CHI's Health Innovation Implementation Committee (HIIC) selected a set of measures to track longer-term results of the project, including:

- Rate of uninsured children ages 0 – 18 in King County and Washington State
- Well-child visit rate for CHI enrolled children ages 3 – 6
- Immunization rate for CHI enrolled children
- Rate of preventable ER visits for CHI enrolled children
- Rate of preventable hospital admissions for CHI enrolled children

- Parents' level of confidence in their ability to access needed services for their children
- Parents' perceived ease of accessing needed services for their children
- Parents' perception of their children's health status
- Number of school days missed due to illness
- Number of parent work days missed due to child's illness

The telephone interviews conducted by the Gilmore Research Group with families enrolled in public health insurance coverage through the CHI provide data for the last five measures in the list above.

Methodology

The family interview questionnaire was designed based on instruments used in the evaluation of the Healthy Kids program in California, developed and pre-tested by the Center for Community Health Studies at the University of Southern California, and the Consumer Assessment of Healthcare Providers and Systems survey, developed and administered by the US Department of Health & Human Services' Agency for Healthcare Research and Quality. The interview guide was translated into Spanish, given the population of families enrolled, and both English and Spanish versions pre-tested in November 2008. A copy of the interview guide can be found in the Appendix.

Two groups of families were selected for inclusion in the interview process. First, all families in the accepted application pool who enrolled their children in public health insurance coverage through the CHI during July, August, and September of 2007; second, all families in the accepted application pool who enrolled during the one month period prior to survey administration, November 2008. The children enrolled in the 2007 time period will have had the opportunity to complete a medical appointment, thus establishing a medical home. Those enrolled in the more recent time period likely will not have had sufficient time to complete an appointment and served as a comparison group, representing children without a medical home and without previous health coverage.

Contact letters, in English and Spanish, were mailed from PHSKC to each household, alerting parents/guardians of the upcoming interview, its purpose and the use of the data, and the voluntary and confidential nature of the interview. A $20 gift certificate was offered as an incentive to those who participated in appreciation for their time. A copy of the sample contact letter can be found in the Appendix.

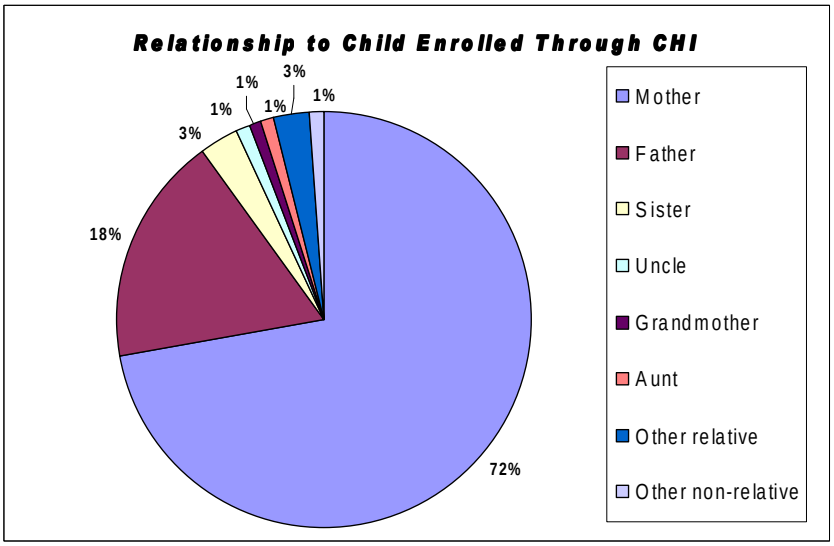
During December of 2008, Gilmore Research Group completed 153 family interviews. This represents a response rate of 77% of families available for interviewing (82% of newly enrolled families and 71% of established families) and 58% of the total of 431 families from

the applicant pool. The table below shows the disposition of the calls to families included in the process.

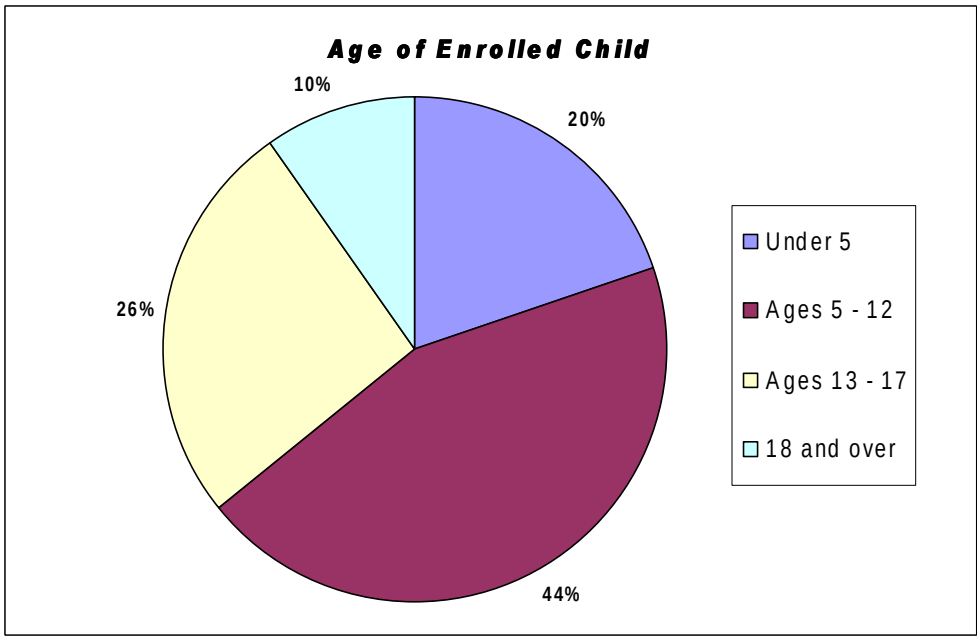
Call Result	Total	New Enrollee	Established Enrollee
Total available	431	218	213
Completed interview	153	88	65
Refusals	46	20	26
No answer/Answering machine/ Busy signal	54	32	22
Wrong number/No one by that name at this number	47	19	28
Disconnected	101	40	61
Business	3	2	1
Fax/Modem/Blocked	9	5	4

Characteristics of Interviewed Families

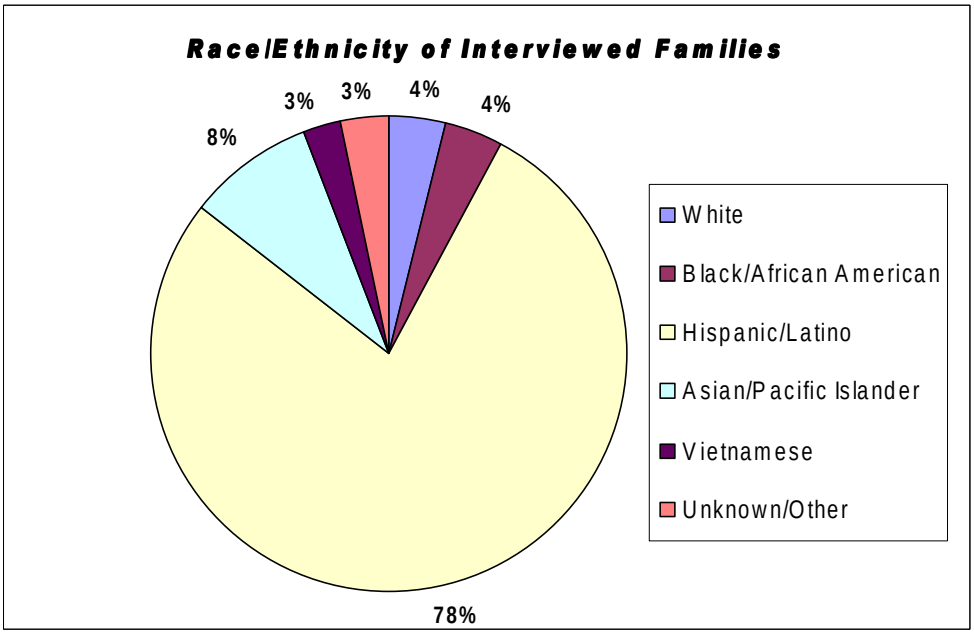
Most of the interviewed family members were mothers of children enrolled through the CHI (72%), but a significant minority were fathers, sisters, uncles, grandmothers, aunts, or other relationships. The chart below shows the different family members that were interviewed by their relationship to children enrolled through the CHI.



Interviewed families had children ranging from under age 5 to over age 18. The predominant age category was ages 5 – 12, representing 44% of interviewed families. The following chart shows the distribution of enrolled children in interviewed families by age group.



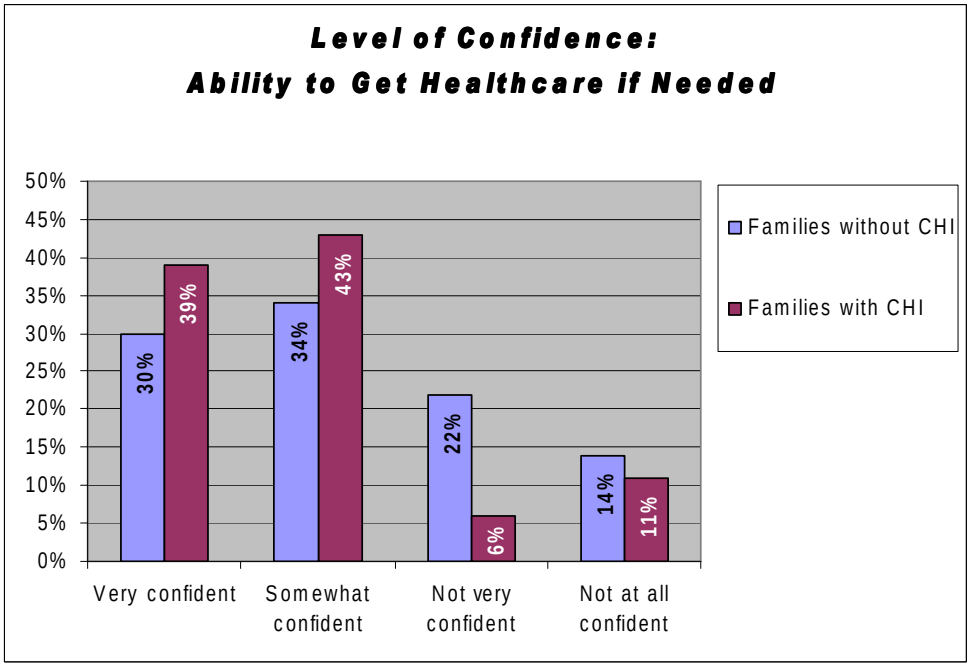
Interviewed families were racially and ethnically diverse, with a majority (78%) of Hispanic/Latino families. The chart below shows the distribution of interviewed families by race and ethnicity.



The most prevalent primary language among interviewed families was Spanish, followed by English. Reflecting the large number of Spanish-speaking families, the majority of interviews were conducted in Spanish. Approximately three-quarters of interviews were conducted in Spanish. One-quarter were in English, including the Asian/Pacific Islander, Vietnamese, and all other respondents.

Parents' Confidence in Ability to Access Services

Interviewers asked families how confident they were that they could get healthcare for their children if they needed it. Families with CHI were considerably more confident about their ability to get healthcare for their children than the families without CHI. Compared to a total of 36% of families without CHI that reported they were "not very" (22%) or "not at all" (14%) confident about their ability to get needed healthcare, only a total of 17% of families with CHI reported that they were "not very" (6%) or "not at all" (11%) confident. This suggests that CHI programs have been effective not only in insuring children, but also in linking them with a regular source of medical care.

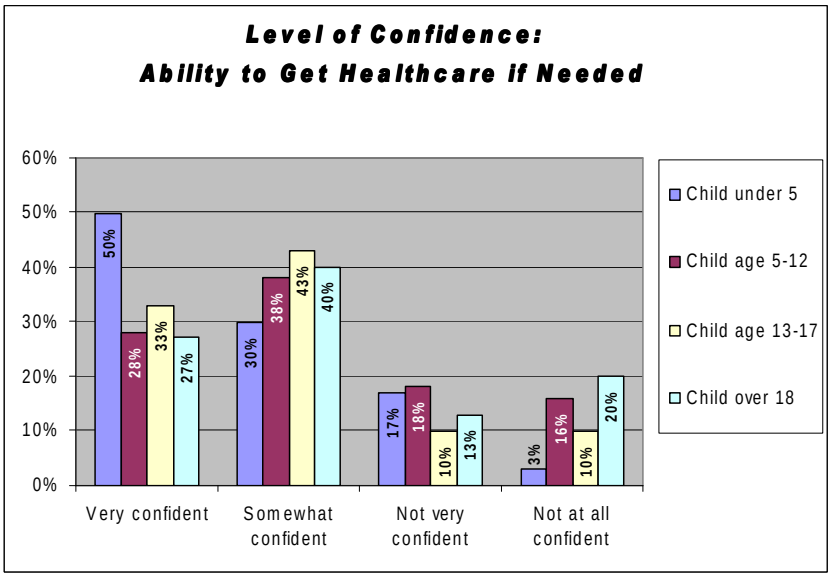


An evaluation of three Healthy Kids programs in California found similar results concerning parents' level of confidence, although King County's families with CHI were not nearly as confident about their ability to get care as were parents in any of the California counties. In Los Angeles, 55% of families with Healthy Kids were very confident that they could get healthcare for their children if needed, compared to 28% of families without Healthy Kids through the California program. Results from San Mateo and Santa Clara counties also reaffirm an impact on parents' levels of confidence. The chart on the following page shows the percent of parents reporting they were very confident in their ability to get healthcare in King County and the three California counties.

County	Percent of Parents Very Confident in their Ability to Get Healthcare if Needed	
	Families without CHI/Healthy Kids	Families with CHI/Healthy Kids
King	30%	39%
Los Angeles	28%	55%
San Mateo	41%	75%
Santa Clara	41%	66%

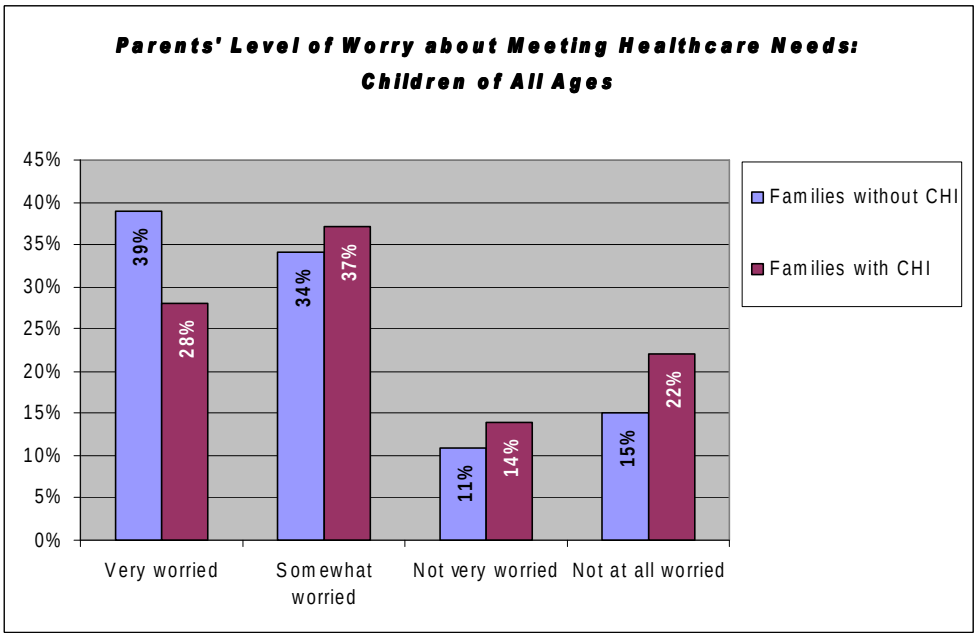
Children Under Age 5

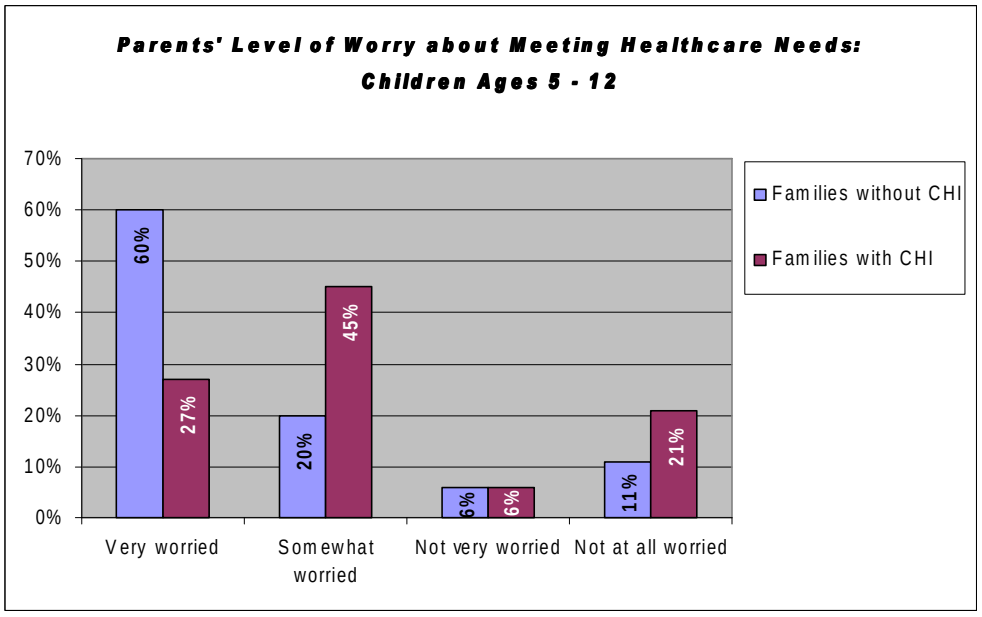
In addition, families with children under age 5 in both the "with CHI" and "without CHI groups" provided responses that were different from families with older children concerning level of confidence and a number of other categories, often reflecting a more confident and more positive outlook on their experiences obtaining healthcare for their children. This difference may prove to be significant, or not, over time. For example, a full half (50%) of families with children under age 5 were "very confident" that they would be able to get healthcare if their child needed it, compared to 28% of families with children ages 5 – 12. The following chart shows levels of confidence by age group.



Level of Worry

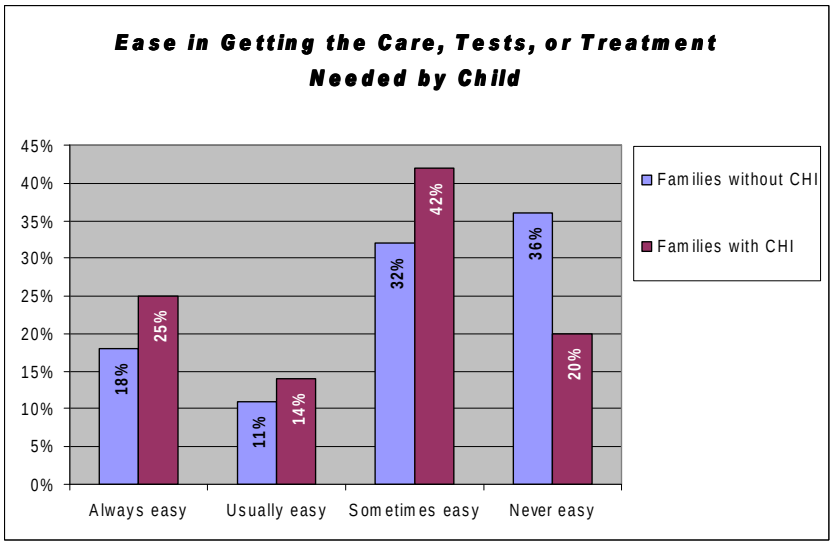
Interviewers also asked parents about their level of worry about meeting their children's healthcare needs. While reported concern about meeting their children's healthcare needs was not significantly different between families with and without CHI overall, there was a significant difference among the subset of families with children ages 5 – 12. While 60% of families without CHI in this age group reported that they were "very worried" about meeting healthcare needs, only 28% of families with CHI reported that they were "very worried."



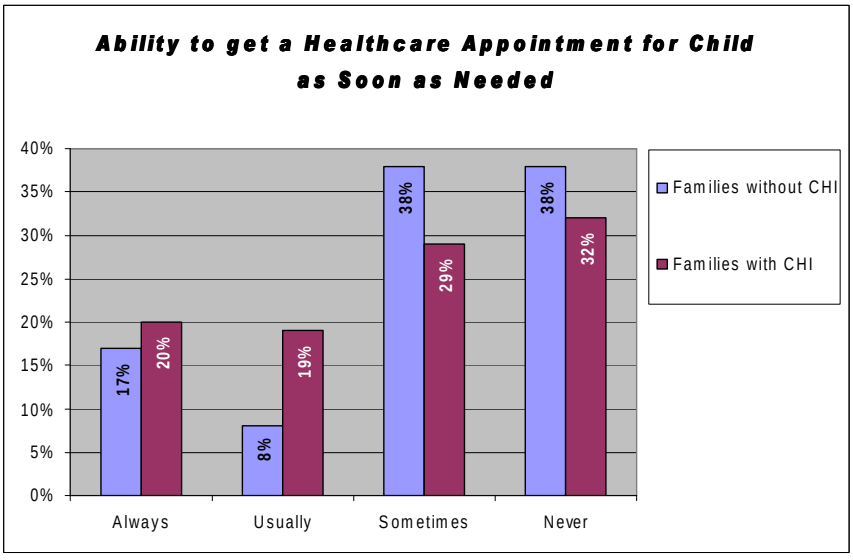


Perceived Ease and Satisfaction with Services

Family interviews found that families with CHI reported greater ease in accessing services than families without CHI. More than one third (36%) of the "without CHI" families reported that it was "never easy" to get the care, tests, or treatment they thought their child needed. This dropped to 20% among families with CHI. Similarly, 30% of families without CHI reported that it "was a problem" to get a satisfactory personal physician or nurse for their child, compared to 11% of families with CHI.

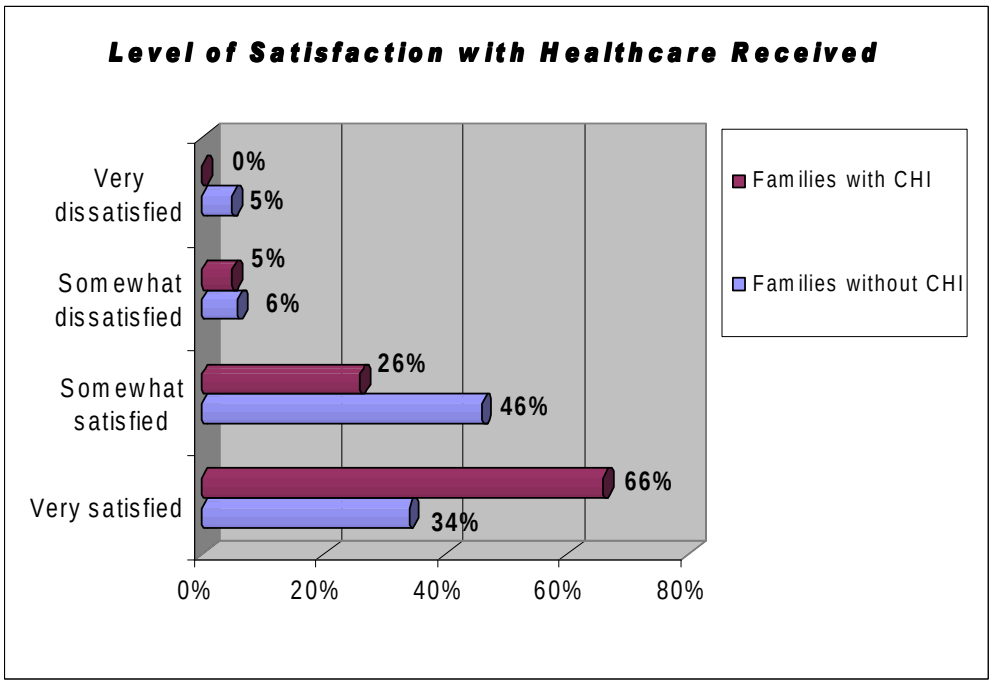


Families with CHI also rated the speed with which they could get an appointment for their children more positively than families without CHI. The chart below shows how interviewed families responded to a question about how frequently they could make an appointment for healthcare as soon as they thought it was needed.



Satisfaction with Healthcare Received

Interview results show that 92% of families with CHI (compared to 80% of families without CHI) were satisfied with the quality of the healthcare they received. Of these families, 66% said that they were "very satisfied," a rate similar to that found in an evaluation of San Mateo's Healthy Kids program, where 70% of families with Healthy Kids were "very satisfied" with the care they received. *(To find out more about this finding online, go to: http://www.cchi4kids.org/docs/USC_chi_impact.pdf.)* These differences, showing a more positive experience in both quality and ease for families with CHI, suggest that the CHI's work to establish linkages with medical homes and its work with medical provider partners may be reducing barriers to accessing care.

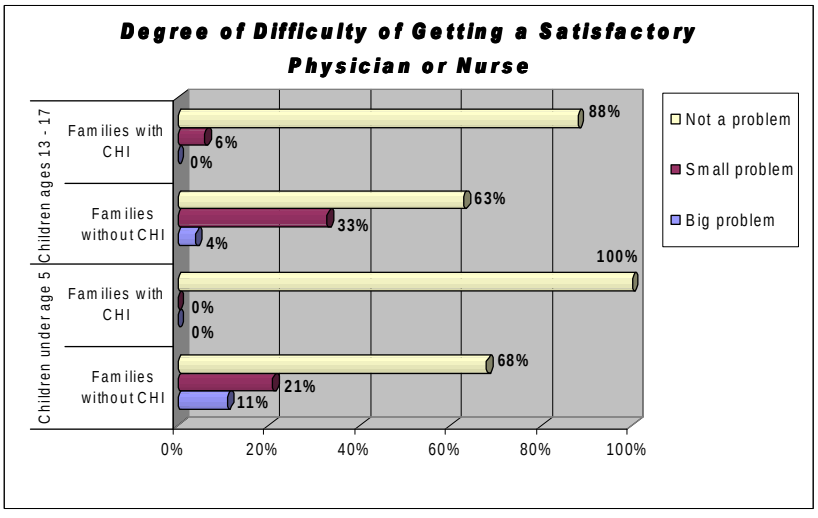


Satisfaction with healthcare received was considerably higher among families with CHI in King County and in Healthy Kids programs in California. The following table shows the percentages by county. In this case, ratings from King County's families with CHI were more commensurate with one of the California counties (San Mateo) for which data were available.

County	Percent of Parents Satisfied with Healthcare Received	
	Without CHI/Healthy Kids	With CHI/Healthy Kids
King	34%	66%
Los Angeles	Not available	Not available
San Mateo	59%	69%
Santa Clara	48%	78%

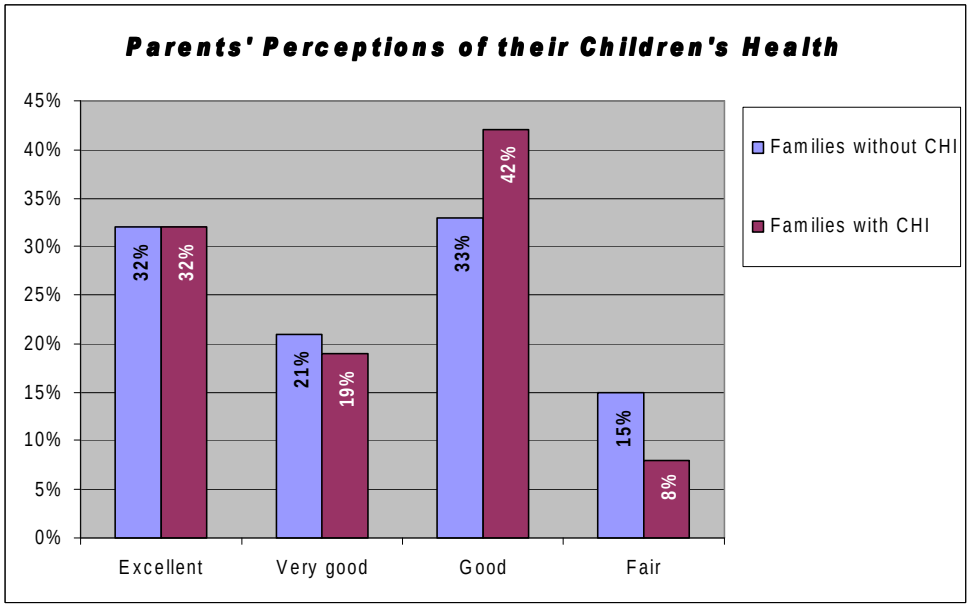
Families with children under age 5 were most likely among all age groups to be "very satisfied" with the quality of healthcare that they received, at 67%. Additionally, over a quarter (27%) of families with children under age 5 reported that they were always able to get an appointment for healthcare at a physician's office or clinic as soon as they thought their children needed it. In comparison, only 10% of families with children ages 13 – 17 felt that they were always able to get an appointment.

Analysis of families' reported happiness with their personal physician or nurse also shows differences in satisfaction among families with CHI in the under 5 and 13 – 17 year age groups. While 68% of families without CHI with children under age 5 reported "no problems" with their personal physician or nurse, 100% of families with CHI reported "no problems." Similarly, 63% of families without CHI with children ages 13 – 17 had "no problems" with their personal physician or nurse, compared to 88% of families with CHI.



Perceived Child's Health Status

Interviewers asked families about how they perceived their children's health. Their responses overall do not indicate a significant difference between families with and without CHI. However, families without CHI were more likely to describe their children's health as "fair," while families with CHI were more likely to rate their children's health more positively—describing it as "good." The chart below shows how they responded.



Impacts on children's health may well take more than a year to develop. Early indicators that families with CHI are less likely to evaluate their children's health negatively are promising. Time will tell if impacts in this area continue to grow.

Data from counties in California with children's health initiatives similarly fail to show significant increases in parents' perception of their children's health after one year of enrollment. The table on the following page shows the percentage of parents in each county who described their children's health as "very good" or "excellent." King County interview results are slightly higher than those seen in the California groups, but not significantly so.

County	Percent of Parents who Perceive their Children's Health as "Excellent" or "Very Good"	
	Families without CHI/Healthy Kids	**Families with CHI/Healthy Kids**
King	53%	51%
Los Angeles	43%	47%
San Mateo	42%	44%
Santa Clara	Not available	Not available

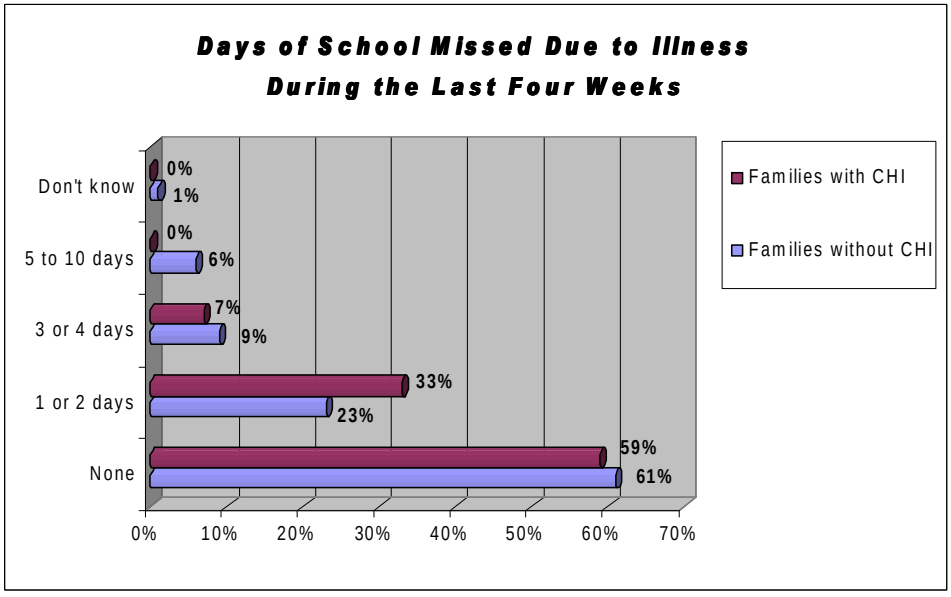
School and Work Days Missed

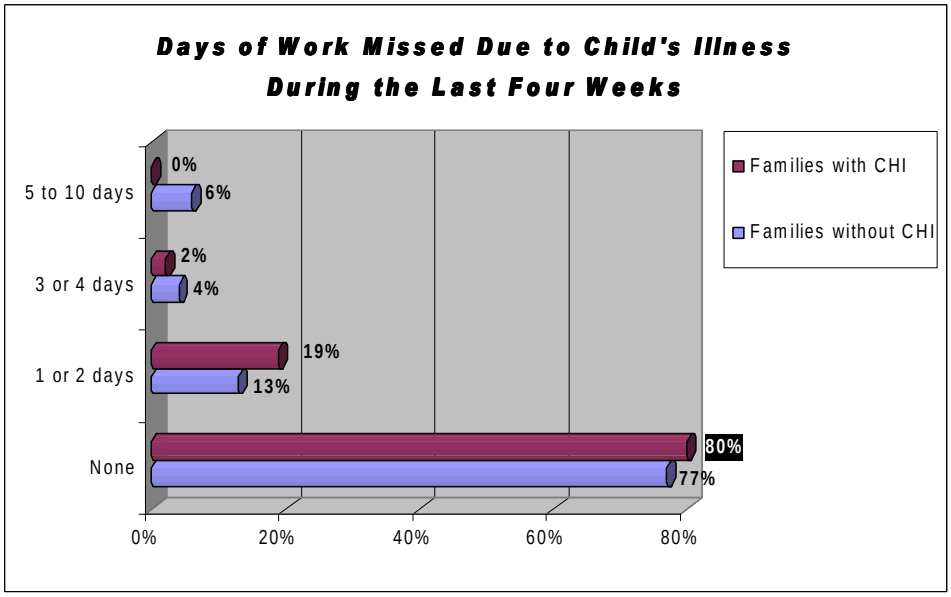
The impact of CHI strategies on school and work days missed was not immediately apparent in data from family interviews. Families with and without CHI reported missing similar numbers of days of school or work due to illness over the last four weeks. However, a difference surfaced among families missing more than four days of school. None of the families with CHI reported missing more than four days of school or work, but 6% of families without CHI reported that they had missed between five and ten days of school or work in the last four weeks. While this difference impacts only a small number of families (four families without CHI), the impact of missing five to ten days of school or work within a four week period can be quite substantial, and therefore is of note.

An evaluation of Santa Clara's Healthy Kids program includes a similar finding, with the percentage of children missing school for three or more days decreasing from 11%, for those not connected with Healthy Kids, to 5%, among those with Healthy Kids. The following table shows school days missed among families in King County, San Mateo County, and Santa Clara County.

County	Percent of Parents Reporting Three or More School Days Missed Due to Illness During the Last Four Weeks	
	Families without CHI/Healthy Kids	Families with CHI/Healthy Kids
King	15%	7%
Los Angeles	Not available	Not available
San Mateo	18%	14%
Santa Clara	11%	5%

The charts below show the number of days of school and work missed by families with and without CHI.





Looking Forward

Data from the family interviews show progress towards the CHI's goals. Among its accomplishments, the initiative helped families experience greater ease and gain confidence in accessing the health services they needed for their children. In addition, none of the surveyed families with CHI reported missing more than four days of school or work due to a child's illness.

The CHI will continue to collect data and monitor its progress. In the coming months, the CHI will measure progress in other "big picture" areas, including preventable emergency room visits and hospital admissions, immunization rates, and well-child visits. This information, together with information from the interviews about families' experiences in accessing healthcare and impacts on children's health and days of school and work missed, will provide the CHI with a broader sense of its progress toward the initiative's goals of improving children's access to care and their health, and reducing avoidable costs.

F. Access & Outreach Program Process Evaluation — May 2009

Terminology

This process evaluation tracks the strategies of the King County Children's Health Initiative (CHI) as a whole. Several different types of staff contribute to the initiative, each with different responsibilities, skills, and areas of impact. In addition, Public Health–Seattle & King County (PHSKC) staff that are not part of the CHI contribute in related areas, such as helping families at public health clinics to apply for health insurance. The responsibilities of the different categories of staff that are referenced in this report are briefly described below.

Application Workers (part of the Access and Outreach team)

Application workers are PHSKC staff who locate uninsured children throughout King County, help families apply for health insurance and other public benefits for which they are eligible, follow up with the Department of Social and Health Services (DSHS) to ensure that eligible children are enrolled, and help link the children to medical and dental homes.

Care Coordinators

Care coordinators are safety net clinic staff, funded by CHI contracts, who ensure that children receive preventive services and that children get referrals to appropriate specialty or community services. They also help families encountering barriers to make and complete appointments for medical and dental care.

Client Services Specialists

Client services specialists work at public health clinics, but are not part of the CHI. They help families complete applications for health insurance, but do not help them enroll in other public benefit programs.

Community Health Workers

Community health workers are staff at nonprofit agencies, funded by CHI contracts, serving culturally diverse and frequently non-English speaking families, who identify uninsured children and assist their families in enrolling children in health insurance and finding a medical and dental provider.

Health Educators

Health educators are PHSKC staff who work with families and community agency staff to inform them about the importance of preventive primary care, the common health or developmental problems that can develop without preventive care, how to establish medical and dental homes, and the availability of public health insurance.

Promotoras

Promotoras are Spanish-speaking community volunteers, supervised by a PHSKC health educator, who locate uninsured children in their communities, help families enroll in health insurance, and connect them with a medical and dental care provider.

Step One

Locating low-income families and informing them about the availability of health insurance coverage for their children

Key Findings

1. The current multi-faceted approach to connecting with families and helping them enroll in health coverage for their children is essential to the Access and Outreach Program's (the Program) success.

☞ There is no substitute for community outreach by trusted individuals to reach families that are not connected to the health or social services system.

☞ PHSKC outreach workers' relationships with community agencies greatly expands the number of sites that are identifying potentially-eligible families.

2. By making effective use of the existing trained staff and supervisors for PHSKC's component of the Program, the effort avoided many of the pitfalls of other new initiatives, i.e., a slow start and disappointing results during the early years.

3. Outreach workers need flexibility in how they carry out their roles. They need to be able to *take the ball and go with it* in order to figure out which strategies work best and pursue them. It also allows them to build on their strengths.

4. Efforts to get the word out must be continuous because there are new families constantly entering the county, as well as families whose circumstances have changed.

5. Establishing a good reputation in the community is important. Being consistently available in the community over the course of years helps to build a positive reputation. Outreach workers gain people's trust by treating them with respect and providing useful solutions to their problems.

PHSKC uses two primary approaches to identify families, assist them in completing health insurance applications for their children, and advocate for their successful enrollment in coverage.

- ☞ The CHI, utilizing PHSKC's Access and Outreach team, provides community outreach to locate and enroll eligible families. Finding families that need assistance with enrollment is often more difficult than convincing them to enroll.

- ☞ In addition to the CHI, PHSKC and community clinics provide on-site enrollment that targets the large number of families that already have connections to the service delivery system. This creates an avenue for these families to apply for health insurance coverage for their children.

What Makes the Community Outreach Process Effective

Outreach workers extend the range of the program by establishing strong connections with community agencies, such as schools, preschools, community centers, community clinics, social service agencies, community centers, etc. This creates a wide-ranging referral network for uncovered families Schools are a particularly effective avenue for outreach workers. Outreach workers have established relationships with front-line office staff, nurses, social workers, and administrators in the schools who can identify students without health insurance and encourage their parents to seek coverage for them. Parents also tend to trust people at schools, so outreach workers do not have to spend as much time establishing a trusting relationship.

Attending regularly scheduled or required meetings, such as the Head Start family night at schools, has been an effective way of reaching parents.

Outreach workers' ability to meet clients in different locations helps overcome transportation issues and some clients' reluctance to leave their neighborhood. Some families are hesitant to travel far from home and the area that they know.

The *promotoras* enable expanded outreach to parts of the community that may not trust social service agencies a great deal or that may have other barriers in reaching services. They are effective in reaching out to Latino families, many of whom may be unwilling to seek assistance at a mainstream agency.

Word of mouth or one-on-one contact are among the most effective ways to reach people, but multiple methods of communication work the best. If families have already heard about the Program on the radio or television, they are more likely to be interested when they talk with an outreach worker.

Flexible hours, including weekends and evenings, are important since many potentially-eligible parents work during the day.

Outreach workers that speak the same language as the communities they are targeting are essential, also sharing the same culture is ideal.

Creating materials in multiple languages is critical, as is giving presentations for those who do not read.

It takes time for workers doing outreach to find their niche among the various people and programs trying to help communities.

Being visible in the community, by going to meetings and talking to people, eventually leads to becoming the go-to person whom agencies know to call when a family needs assistance. It takes time to build a personal relationship with staff at agencies or departments where outreach workers want to meet families. Spending time there regularly and becoming familiar makes the staff more likely to call for help for a client or to request a presentation.

Developing relationships with providers is important because it helps the outreach workers encourage healthcare providers to see children in need of care who have submitted applications for coverage but have not yet been approved.

Providing families with information—where the information they submit goes, the services they can get, and why having coverage for preventive care is important—helps to build trust. Providing families with information about opportunities for their children is more persuasive than telling them what to do. For example, health educators teach families that cavities in baby teeth can lead to cavities in adult teeth, rather than telling them that they must bring their children to the dentist

What Makes the On-site Enrollment Process Effective

While not a direct component of the CHI, an issue that arose in interviews was the large volume of families using the healthcare services offered at PHSKC's clinics. While at the clinic, PHSKC staff determine whether the family has applied for any health insurance coverage for which the children are eligible. This offers a very efficient means of screening many families, already seeking care, to identify those who should complete an application.

Step Two

Assisting families with the application and enrollment process

Key Findings

1. Program staff are expanding local agencies' capacity to identify and enroll families in health insurance and other public benefit programs, and link them to care through training and information-sharing.

2. PHSKC's outreach efforts have been more effective in enrolling eligible families than the community-based organizations (CBO) under contract to provide this service. This may result from the agencies' lack of experience in this task, the amounts of funding provided, and/or their inexperience with performance-based accountability approaches. It is possible that CBOs may be highly effective in identifying and informing many families about their potential eligibility for coverage, who then apply on their own or with assistance from other sources. However, unless the CBOs help the families complete the application process, their impact on application and enrollment will not show up in the data that is available.

3. The in-clinic application and enrollment process is narrower in scope and focuses on medical access, rather than additional services provided through the community-based outreach efforts. For example, community-based outreach efforts can facilitate access to other programs, such as food stamps and utility assistance.

4. The DSHS is viewed as the primary stumbling block in the application and enrollment process for numerous reasons, including DSHS staff turnover, communication difficulties, and their propensity to reject a surprising number of *eligible* families' insurance applications. Outreach staff spend a great deal of time advocating with DSHS staff regarding submitted applications. At the base of this issue is likely the different focuses in the missions of CHI and DSHS workers to enroll the maximum number of children and to ensure that ineligible children are not enrolled.

What Makes the Application and Enrollment Processes Work

Helping families apply for multiple forms of assistance not only is more convenient for the family but also incorporates some efficiencies, since outreach workers get a good sense of what families will qualify for while helping them with the application for children's health coverage.

Families that complete their insurance applications either at a clinic or with the outreach worker are more likely to successfully enroll than those that take the application home and

complete it on their own. One major reason for this is that outreach workers are prepared to help families deal with complex application and enrollment challenges. A common issue that complicates enrollment is documentation of employment, especially when parents transition between jobs fairly quickly. Parents may have difficulty tracking down a former employer, or they may be reluctant to go back because they were fired or quit on bad terms. Some employers refuse to fill out the documentation, especially if they are paying wages in cash. Self-employment can also be difficult to document.

People Point, a City of Seattle program, provides a bridge to benefits for many low-income families by helping them obtain health insurance, basic food, child care, tax preparation, and utility assistance services. PHSKC's Access and Outreach staff that participate in People Point have trained CHI staff to enroll families in some of these programs, as well as insurance for children.

The Parent/Child Health Program forges connections among PHSKC programs that serve children and families. This is a critical function as programs change regularly, and staff need to know what is available for newly-enrolled clients.

The Child Care Health Team works with child care providers to sign up low-income families for health coverage at child care sites or to identify families that need assistance and refer them to CHI staff.

The monthly First Friday Forums involve the agencies that are enrolling families in public insurance coverage, including DSHS, the health plans, PHSKC clinics and outreach program, and the community clinics. In addition, advocacy organizations, such as the Children's Alliance, are regular participants. The forums keep the many agencies engaged in increasing children's health enrollment and moving in the same direction in a coordinated way.

The training and information updates Program staff provide to other agencies expands their capacity to identify and refer families to the CHI and/or to help them enroll in health coverage. This multiplier effect results in a significantly greater system-wide capacity to enroll families in health insurance and other public benefit programs.

The time spent developing a working relationship with DSHS and the Community Service Office (CSO) staff is producing results. The continuous problem-solving efforts make it possible for more families to obtain coverage, as well as improving DSHS's response when working with families applying for other types of assistance. The improvement in this working relationship began with the Access and Outreach program, which built better relationships with CSOs. The CHI has contributed to improved relationships with DSHS managers as well.

Where the Processes Appear to Break Down

The DSHS CSO staff appear to pose the major problem in creating a smoothly-functioning application/eligibility determination/enrollment process. Note: This process evaluation did not include interviews with DSHS staff; thus, their perceptions of PHSKC and community agencies as system partners are not known.

The outreach workers' priority is to successfully enroll families in the health insurance programs for which their children are eligible. Perceptions are that the CSO staff's priority is to serve as a gatekeeper for these same health insurance programs. This gate-keeping function includes rejecting numerous families' applications, even though many prove to be eligible following advocacy work and submittal of additional documentation by the outreach staff. This additional advocacy work represents a significant system inefficiency.

PHSKC managers estimate that an inordinate amount of their outreach workers' time and energy go into obtaining approval from the CSOs for *eligible* families' applications, including processing applications, gathering and faxing documentation, problem-solving to obtain special documentation, and following up with both clients and DSHS. Outreach workers may spend close to 10 hours per week on the phone with DSHS workers regarding their clients' eligibility for health insurance coverage. It appears that it is the clients whose circumstances are slightly different from the norm that generate the most challenges, e.g., a client who is self-employed. Advocacy with the CSO staff regarding these applications, which represent approximately 20% of those submitted, consumes an inordinate amount of the outreach workers' time.

Indirect outreach activities also require a great deal of the outreach workers' time, e.g., checking voicemail for messages from clients and DSHS, checking on the status of submitted applications, completing paperwork, and entering information into the database.

Program staff believe that many families seek their help because the application process has just become too difficult and too confusing. Many families find the letters they receive from DSHS to be unclear and convoluted. Therefore, some families probably drop out before they even contact Program staff because they do not believe they are eligible.

The perception is that most of the problems in processing the families' applications are the result of the CSO staff's lack of training, high staff turnover, and the use of inconsistent approaches to eligibility determination. The perception is that DSHS could improve its employee training efforts to help CSO employees provide a consistent level of service and increase their understanding of the insurance eligibility requirements.

These factors may also be exacerbated by CSO staff caseloads (which are large), the impact of multiple supervisors providing the CSO staff with inconsistent information and messaging about enrollment, the cumbersome nature of the DSHS data systems, and the separation of the application and enrollment functions into different sections within DSHS.

A number of outreach staff take advantage of problems with CSO staff to communicate with them and jointly solve problems. For example, when a particular CSO staff member denied six families' applications because of citizenship issues, Access and Outreach staff were able to bring this problem to the attention of DSHS managers and point out the need for staff training on how citizenship issues impact eligibility.

In addition to the challenges many families face while enrolling in health coverage, many of the applicant families are receiving services from multiple DSHS programs. Many of these programs operate out of separate *silos.* DSHS does not offer a unified approach to enrollment for these multiple programs; rather, the state systems operate discrete application and enrollment processes for individual programs. Families must work hard to keep all of their eligibility and enrollment information up to date and coordinated. PHSKC outreach staff work with families to help them learn how to navigate these systems; however, their time is limited and not all clients are able to take on this challenge.

One reason that progress with DSHS has occurred is that outreach lead staff's job responsibilities call for them to identify system problems, alert DSHS to these problems, and advocate for system changes. For example, one result of the discourse between CHI and DSHS staff is that CHI staff can now communicate with DSHS regarding specific clients by email using a unique identifier code. This option is only available in King County.

While a number of negative aspects of the role played by DSHS in the enrollment and eligibility processes came up, DSHS has done a good job getting input from outreach staff and tried to work collaboratively to smooth out the application process.

The barriers presented by poverty also play a powerful role in reducing families' ability to become and remain enrolled in health coverage. Families move often and do not remember to alert DSHS to the address change, their phones are cut off, or they are working and do not have time to complete the applications for coverage. Program staff work hard to help families become covered and hang onto their coverage. Families coming in are often *overwhelmed in their lives* and have so much going on that they cannot connect in any consistent way, needing support throughout the enrollment and linkage to care process.

Break-downs in the client end of the application process appear to happen most frequently when there are missing pieces to the application, e.g., pay stubs, Social Security numbers, etc. Even with Access and Outreach staff assistance and follow up, sometimes families are unable to supply the required information, and DSHS denies their application.

There are also application and enrollment challenges within PHSKC. Program staff and managers hold different perspectives on the contribution client services specialists should make to the application and enrollment effort. On one hand, some program staff and managers would like the client services specialists to provide the same expanded enrollment opportunities in the clinic settings that the outreach workers provide in the community. From their perspective, the clinic managers do not reinforce the importance of the expanded benefits enrollment role, and therefore, the clinic staff continue to perform a more narrowly-

defined job that results in lost opportunities to help families sign up for other benefits for which they are eligible. On the other hand, some managers and staff point to increased enrollment and approval of health applications and believe that the clinic staff's narrow focus has resulted in greater success in this area.

The community-based agencies contracted for enrollment and linkage work do not appear to be as effective as the Program in helping uncovered families apply for and obtain health coverage for their clients. Service data indicate that PHSKC's outreach and linkage activities yield a much greater number of children enrolled in coverage than do the community agencies under contract. This also results in PHSKC reflecting a significantly lower unit cost for this activity.

Step Three

Helping families connect with a healthcare provider for their children

Key Findings

1. Providing families with all the information they need to identify a healthcare provider, make appointments, and get to the appointments is a critical step in the process.
2. Community clinics are key providers of care for many children the Program enrolls. It is a huge problem when the clinics are maxed out because there are few other alternatives.
3. Dentists participating in the ABCD Program are key, as they are willing to treat children covered by public insurance when most dentists are not.

What Makes the Connection to a Healthcare Provider Work

Outreach workers find that location, office hours, language and culture, and acceptance of coverage are among the most important factors when families select a physician or dentist. For most families that they assist, providing a list of options and information is sufficient. However, when families are unable to circumvent barriers to accessing care, CHI Program staff will provide additional help as needed, including arranging interpretation, following up with physicians' offices to advocate for the client and set up an appointment, and following up with the family to find out if they were able to make it to the appointment and hear about their experience.

Outreach workers provide families with information to try to address access barriers before they arise. They print directions to medical and dental offices, explain how they can use public

transportation, and make sure they know how the coverage will work, e.g., which services will be covered and which costs, such as co-pays, to expect. They tell families the hours the office is open and whether they can expect someone to speak their language.

Staff also provide reassurance to families about the service providers, sharing their personal knowledge of the clinic or dental office. Personal physician and dentist recommendations are extremely effective in linking families to care. The *promotoras*, for example, often live in the same neighborhood as their clients and can recommend clinics where they receive their own healthcare. This serves to encourage families to follow-through, taking the first steps toward building a relationship of trust.

Training, supervision, and the performance orientation of the Program all contribute to workers' attention to families making a connection to a healthcare provider. Ensuring families establish a medical and dental home is a priority. Going the extra mile to discover potential barriers for families and resolving those problems is standard procedure for the workers and one probable reason for the positive results demonstrated in the data available on children visiting a physician or dentist.

The capacity limitations faced by PHSKC clinics and community clinics can create problems for many families seeking medical and dental care. As a primary venue for care for low-income families, the clinics often experience overloads that delay families' ability to obtain care once they have become enrolled in health coverage.

However, data indicate that the Program's efforts are having an effect. Most new enrollees do make a connection to a physician or dentist. However, the data concerning whether this initial connection becomes a long-term medical or dental home, where children continue to obtain care over the long term, is less conclusive.

- ☞ 89% of new enrollees obtained medical care for their children in the year following their enrollment.

- ☞ 60% of new enrollees' children received dental care during the year following their enrollment.

Step Four

Teaching families about the importance of preventive care and ensuring that children receive preventive services

Key Findings

1. Clinic care coordinators are a key component of the CHI program model as designed, working with families in clinics to ensure that children get consistent preventive care. However, while data shows that in many areas they have increased the rate of preventive services among all of the children receiving care at their clinics, data is not available on their impact on CHI-enrolled children specifically.

2. Helping families establish bona fide medical and dental homes is challenging. Families often take their children to the physician or dentist once or twice, particularly to address an acute problem, but have more difficulty forging an ongoing connection that leads to regular preventive care.

3. Establishing effective referral relationships with mental health agencies is even more difficult than with medical and dental providers. The mental health system often turns people away since the rules say *eligibility first, treatment second*. PHSKC staff need to be particularly persistent to obtain help for families with immediate mental health needs.

4. The Program staff work with a variety of other PHSKC programs to provide access to a range of related health services, e.g., services for low-income children and their families, including, the Infant Mortality Prevention Program, the Parent/Child Health Program, the WIC Nutrition Program, etc.

Preventive care is not the norm in many communities, which makes it important for care coordinators, outreach workers, and health educators to explain why it is important. Many parents argue that their child is rarely sick, or feel that they are already at the clinic so frequently, particularly with asthma, and therefore question why they would need to come more often.

Helping families obtain regular medical and dental coverage is a significant challenge. While many families obtain insurance coverage for their children, they may not take them to the physician or dentist regularly, particularly for preventive care. This may be due to work constraints, transportation challenges, and lack of understanding regarding the importance of preventive care. Even though workers try to educate families about the importance of

preventive care, there are so many things going on during the appointment, some of them emergent, it is difficult to spend a lot of time on this message.

Some families have children with a need for immediate care. This motivates them to go through the application and enrollment process. Once they have met that immediate healthcare need, they may fail to renew their coverage and not continue obtaining medical and dental care until the next crisis comes up. This is where a positive relationship between the healthcare provider and the family is really critical.

Sixty to seventy percent of low-income families cannot use sick leave to take their children to the physician or dentist. For this reason, many parents take their children to the emergency room at night to avoid missing work and the associated lost wages. This lack of family-friendly leave policies places the children at risk of missing necessary preventive care.

Some families also feel they are not treated well at the clinics, e.g., they are treated differently from other clients, are treated disrespectfully, have to wait over an hour for their appointment, subjected to dirty waiting rooms, etc. These families often decide not to go back based on their initial experience.

The Overall Systems Perspective

Key Findings

1. Implementation of the Program occurs in multiple organizational units within PHSKC. This division of responsibility is coordinated effectively by the managers currently in place, whose strong informal relationship helps to ensure that the program functions smoothly. However, this coordination would require attention if staff changes over time.

2. The provision of funding for the supervisory positions is an important ingredient in achieving accountability. The current supervisor to outreach and application worker ratio of 1:4 or 1:5 allows supervisors to provide individual support and training for staff. This has proven important in transitioning the program to a performance-based effort where successful enrollment in coverage and connection to a medical and dental home are priority outcomes.

3. By making effective use of the existing trained staff and supervisors for PHSKC's component of the Program, the effort avoided many of the pitfalls of other new initiatives, particularly a slow start and disappointing results during the early years.

4. The recognition that the Access and Outreach jobs are complex in nature and require significant skills in system negotiation, advocacy, client education, and creative problem-solving leads to hiring and retention of a strong staff group. Successful staff in these positions are detail-oriented with good people skills, strong computer skills, in-depth understanding of the Medicaid eligibility rules and match requirements, and are familiar with community resources in order to make effective referrals.

5. Provision of support staff to assist the outreach workers with the clerical activities that are part of the outreach and application processes frees up outreach worker time to identify additional families and help them apply for coverage.

6. Establishment and use of clear performance standards for the Program staff and tracking performance against these standards on a regular basis provides critical accountability for staff and managers. The supervisory infrastructure in King County's program, and its strong focus on accountability, may be a key factor in the productivity shown by the outreach workers. In addition, the County's utilization of a data tracking system supports performance measurement in an essential way. The more limited infrastructure in place in some of the community agencies under contract to the Program may contribute to their lower level of effectiveness in enrolling and linking children with care.

7. PHSKC's Program has been more effective in enrolling families in health coverage and linking them to care than the community-based organizations under contract to perform these functions.

8. Delivery of staff training at community agencies such as schools, along with the provision of the tools and information CBO staff need on an ongoing basis, helps develop stronger identification and referral, and in some cases, enrollment expertise among PHSKC's community-based partners.

9. The issues identified with DSHS are significant and will require system-level attention in order to bring about needed improvements. The commitment to working in partnership with DSHS and the CSO staff is essential to ironing out the problems that eat up so much of the Access and Outreach staff's time and energy. While the relationship with DSHS and the CSO staff has improved, the time Program staff spend negotiating with state staff for approval of client applications represents an enormous drain on the system. Continuing to work toward resolution is critical.

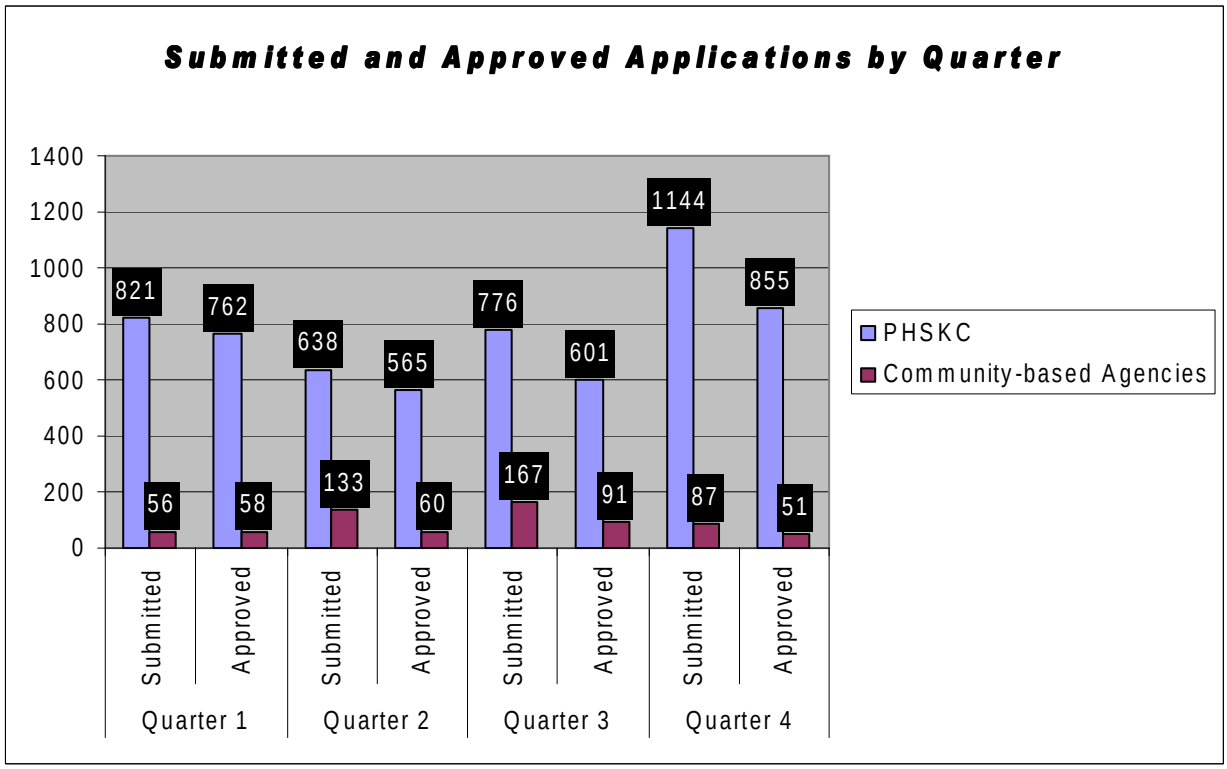
10. The weakest link in the application/enrollment/recertification appears to be the prompt from DSHS for recertification—alerting families about the importance of recertifying their eligibility. This results in families losing their coverage and repeating the application and enrollment process.

2008 CHI Data

Locating and Enrolling Uninsured Children: Submitted and Approved Applications for Coverage

The number of applications for healthcare coverage submitted by PHSKC and community-based agencies and approved by DSHS remained relatively steady over the course of 2008, with the highest number submitted and approved in the fourth quarter. The great majority of applications were submitted by PHSKC, rather than community-based agencies. Applications submitted by PHSKC were also approved at a higher rate.

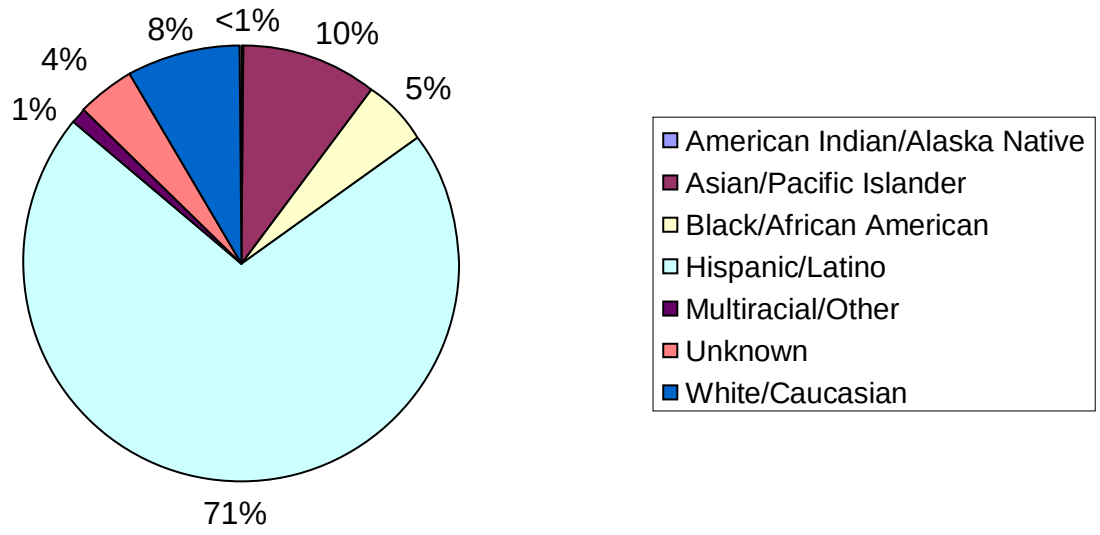
The following chart shows applications submitted and approved, by quarter, for 2008.



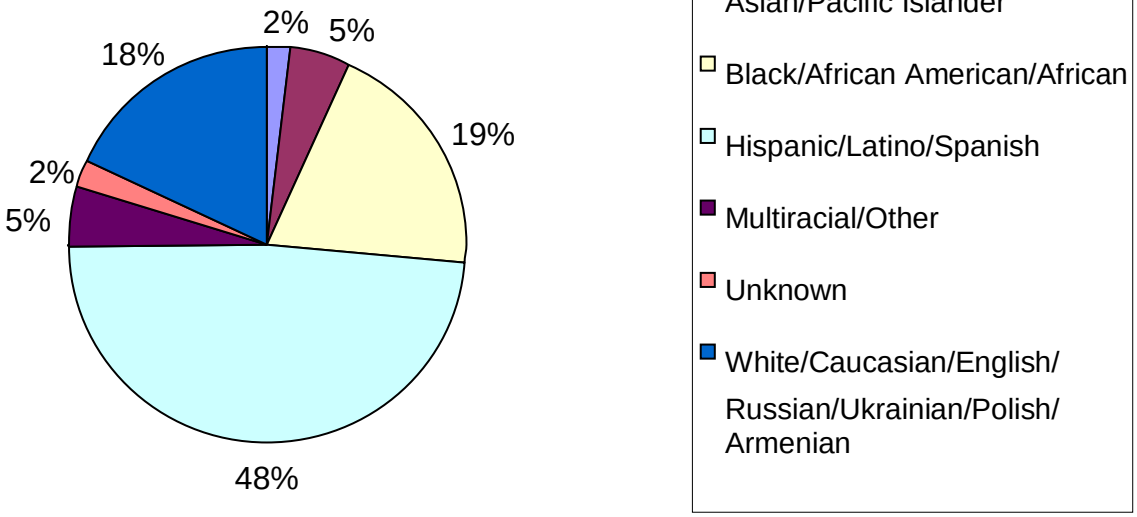
Race and Ethnicity

Both PHSKC CHI-funded staff and community-based agencies were successful in enrolling children from diverse racial and ethnic communities. Overall, PHSKC CHI staff were responsible for approximately 93% of the children enrolled through the CHI. Most (71%) of these children were Hispanic/Latino. In comparison, no one racial group represented a majority among the children enrolled by community-based agencies, where enrolled children were 48% Hispanic/Latino, 19% Black/African American, and 19% White/Caucasian. Refer to charts on the following page.

Race/Ethnicity of Children Enrolled by PHSKC Staff



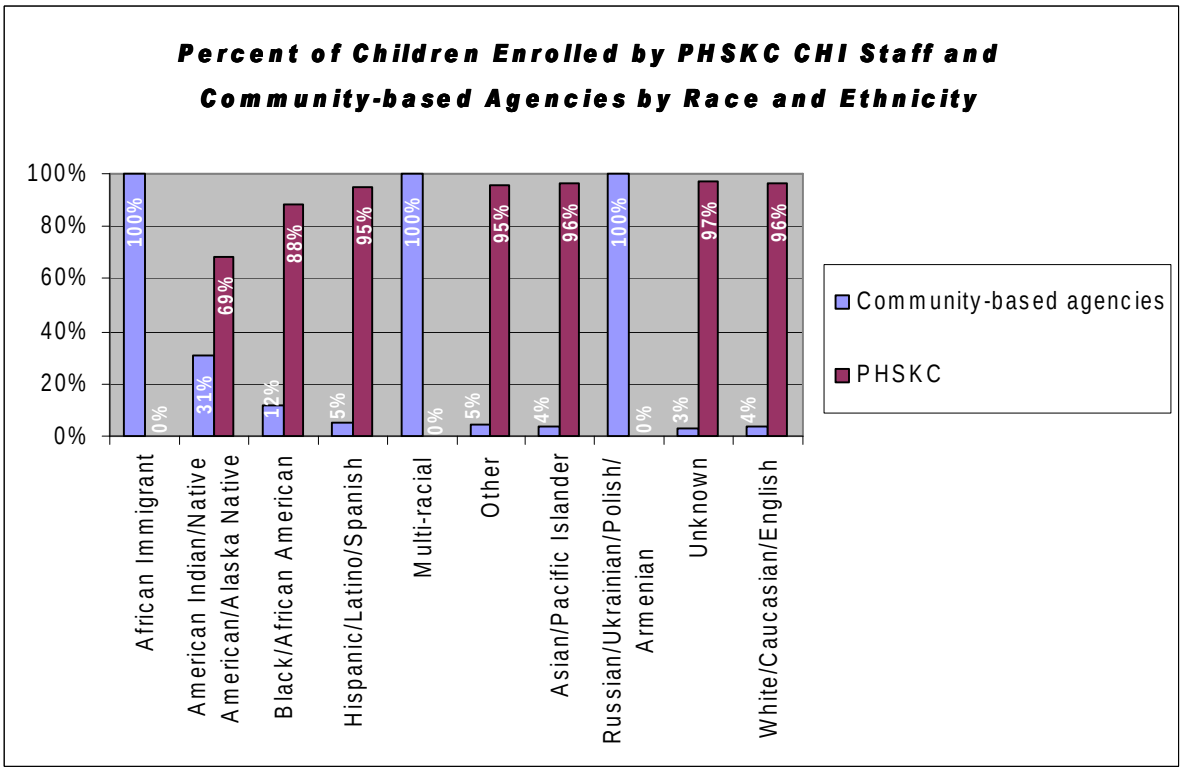
Race/Ethnicity of Children Enrolled by Community-based Agency



PHSKC and community agency staff did not record race and ethnicity in the same way. For example, some agencies listed only race, while others listed only ethnicity or language. In order to facilitate comparison, the preceding charts combine several racial and ethnic categories, which likely contributes to a degree of inaccuracy. For example, all of the children that agencies coded as African immigrants are included in the Black/African American category, although their race is unknown. Similarly Russian, Ukrainian, Polish, and Armenian immigrant children are grouped with White/Caucasian children.

However, although the categorization may contain inaccuracies, comparison of the two charts shows that while the children that PHSKC staff enrolled were comparatively more likely to be Latino or Asian/Pacific Islander, children enrolled by community agencies were comparatively more likely to be American Indian, Black/African American, or White/Caucasian.

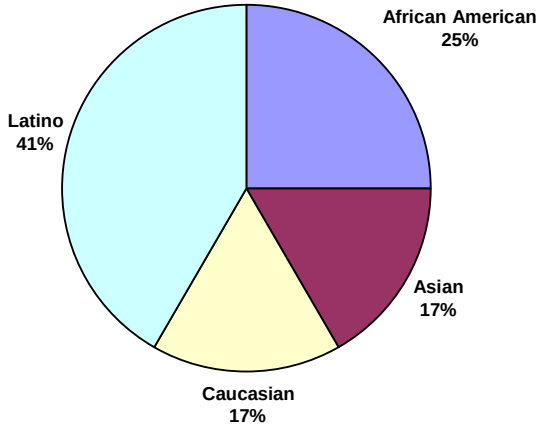
A key goal for the CHI is ensuring access to care for communities more likely to be uninsured and that experience greater barriers to seeking medical and dental care due to language or culture. Therefore, it is important for the CHI to consider impact on enrollment of racial and ethnic groups in making decisions about the best outreach and enrollment strategies. The chart below shows the contribution of community-based agencies compared to PHSKC staff in enrolling different racial and ethnic groups. PHSKC staff are responsible for enrolling the vast majority of children in most racial and ethnic categories, for example enrolling 96% of the Asian/Pacific Islander children. However, one category in which PHSKC staff were somewhat less successful was the enrollment of Native American/Alaska Native children. Of the 32 Native American/Alaska Native children enrolled through the CHI, 69% were enrolled by PHSKC staff and 31% through community-based agencies.



The differences in how agencies coded race and ethnicity make it difficult to compare enrollment of immigrants. While some of the community-based agencies tracked their enrollment of African, Russian, Ukrainian, Polish, and Armenian immigrants, other community-based agencies and PHSKC staff recorded race only, entering these children within broader White/Caucasian and Black/African American race categories. The preceding chart shows enrollment of immigrant children for the agencies that recorded this information separately; however, it would be incorrect to infer that PHSKC staff did not enroll African, Russian, Ukrainian, Polish, and Armenian immigrants.

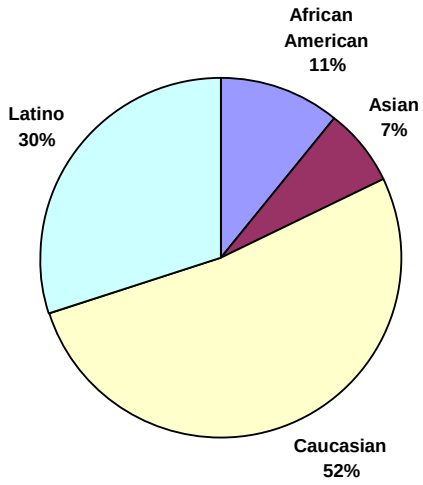
Research has shown that outreach to families is often more effective when outreach staff speak the families' language and share their ethnicity. Therefore, many public health programs strive to hire staff that share the language and ethnicity of the communities that they target for outreach. Analysis shows that the ethnicity of PHSKC CHI staff correlates with the ethnicity of uninsured adults in King County; data on the ethnicity of uninsured children in King County is not available. As the following charts show, PHSKC CHI staff were slightly more likely than the uninsured adult population to be Latino and considerably more likely to be African American or Asian. PHSKC CHI staff were significantly less likely to be White/Caucasian.

Ethnicity of PHSKC CHI Staff



* Caucasian includes one fluent Spanish speaker with strong ties to the Latino community

Ethnicity of Uninsured Adults in King County



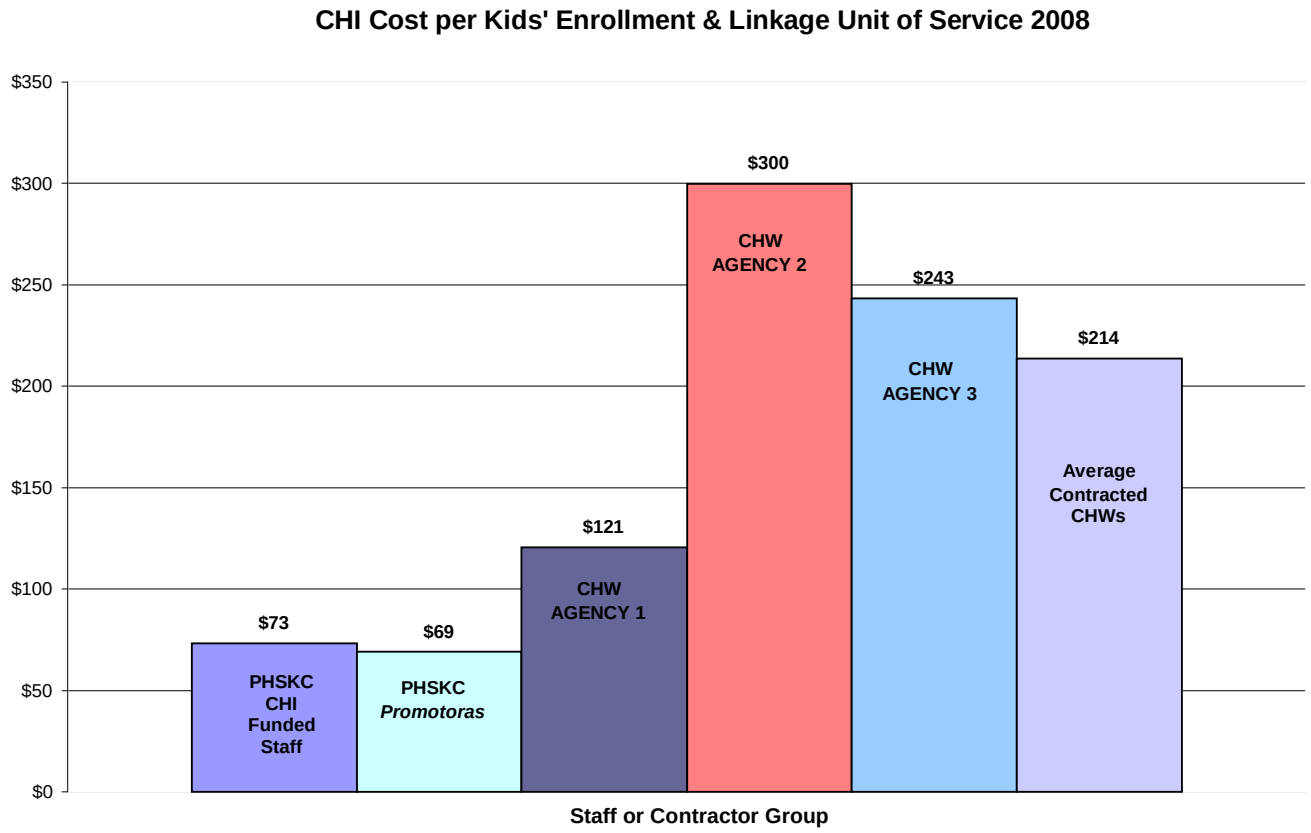
Source: BRFSS -King County adults aged 18-64, for the years 2006-2008 combined. Accurate data for uninsured children unavailable

Enrolling and Linking Children to Medical and Dental Homes: PHSKC CHI Staff and Community-based Agencies

CHI leadership analyzed the costs of enrolling children in coverage and linking them to a medical and dental home through PHSKC CHI staff compared to the cost of enrolling and linking them through staff at community-based agencies. While the cost per child of enrollment and linkage varied considerably between community-based agencies, from a low of $121 per child to a high of $300 per child, PHSKC CHI efforts were less expensive than all of the community-based agencies. The cost per child of enrollment and linkage averaged $73 for those connected through PHSKC CHI staff.

The chart below shows each agency's cost per child enrolled and linked. This is defined as the combined total of the number of children enrolled, the number of children seen by a physician, and the number of children seen by a dentist. Community agencies are referred to by number rather than name because there are many factors that influence their performance, such as length of time since contract start and population. Because these factors are not easily shown

on a chart, it does not include agency names in order to avoid falsely suggesting that a particular agency is performing poorly.



Among all of the enrollment and linkage strategies, the cost was lowest for children connected through *promotoras*, the CHI's Spanish-speaking community volunteers, at $69 per child. PHSKC CHI staff trained 32 *promotoras*, 12 of whom are active. During the first 10 months of the *promotora* program, *promotoras* enrolled 258 children. The *promotoras* were also highly effective in connecting children to medical and dental homes. Children enrolled through *promotoras* attended the following healthcare appointments:

- ☞ 266 medical visits
- ☞ 260 dentist appointments
- ☞ 42 eye appointments

Preventive Care: Health Educator and Care Coordinator Activities

Health educators trained a large number of community agency staff, parents, and caregivers and educated children about the importance of preventive health. Health educators conducted trainings at the meetings of community groups, in schools, at service fairs, and in other venues. Between January 2007 and March 2009, PHSKC health educators:

- ☞ Trained 3,985 staff
- ☞ Trained 4,767 parents and caregivers
- ☞ Educated 4,539 children about preventive health

Care coordinators are responsible for ensuring that children receive preventive care. Data from the six agencies where PHSKC funded a care coordinator shows improvement in most categories for which data is available. Some of the increases are considerable, such as the 257% increase in early oral health visits at one agency. The table on the last page shows the percentage of improvement in delivering preventive services for each of the agencies with care coordinators from the beginning of their contract with PHSKC through December 2008. These statistics show their delivery of preventive services to all of the children receiving services at their clinic rather than delivery of preventive services to CHI children specifically. Because their performance is so strongly impacted by different factors, such as population and contract start date, the agencies are referred to by number rather than name in order to avoid falsely suggesting that a particular agency performed poorly.

% Improvement from Contract Start to December 2008						
	AGENCY 1	AGENCY 2	AGENCY 3	AGENCY 4	AGENCY 5	AGENCY 6
Immunization	6% increase (to 73%) for 2 yr olds & 53% increase (to 78%) for 6 yr olds	63% increase (to 96%) at clinic 1 & 32% increase (to 91%) clinic 2		79% increase (to 88%)	22% increase (to 61%)	
Well Child Check	13% decrease (to 60%)		4% increase (to 74%)			
Early Oral Health Visits		257% increase (to 50)		49% increase (to 287)	baseline of 0 (to 42%)	114% increase (to 92%)
Fluoride Varnishes			17% increase (to 2706)			104% increase (to 92%) for 0-5 yr olds & 79% increase (to 100%) for 6-10 yr olds
Developmental Screening						3% increase (to 90%)
Autism Screening						baseline of 0 to 92%

G. Advocacy Materials

Driven by Social Justice

The CHI Access and Outreach efforts are targeted to ethnic and geographic communities with the least access to care. Isolated groups that have significant language, cultural and literacy barriers are a particular focus.

Outreach staff and community agency staff speak a variety of languages, reflecting the target populations. Hiring community health workers from existing social networks allows messages about prevention and health promotion to reach vulnerable families in areas with the highest need. This approach led to success in reaching Latino, African-American, and Asian and Pacific Island communities.

The Children's Health Initiative (CHI) was created in 2007 by King County Executive Ron Sims and supported by the King County Council and community partners. It is a public/private partnership to improve low-income families' ability to enroll in federal and state health insurance programs and to ensure that their children obtain appropriate preventive-focused primary medical, dental, and behavioral health care.

"I worked with a family from India whose daughter called, as the parents did not speak English well. She had gotten a flyer about the program from the school nurse because she needed glasses. She got an eye exam and the glasses and called to tell me, "Now I can see." — *Application Worker*

With the recently launched Promotora program Latina community health workers provide health education and assistance in navigating the system, working in the communities where they live. CHI Promotora Griselda Tapia (center) along with her daughter and Health Educators Penny Lara (left) and Anel Mercado (right) provide assistance at the White Center Community Development block party.

For More Information about the Children's Health Initiative:

Contact Rachel Quinn at (206) 296-4165, rachel.quinn@kingcounty.gov or Susan Johnson at (206) 263-8684, susan.johnson@kingcounty.gov.

or see www.metrokc.gov/health/kchap/chi.htm or www.metrokc.gov/exec/initiatives.aspx

(After October 1, 2008 use www.kingcounty.gov/health/chi)

Public Health Seattle & King County

4

King County

CHI Children's Health Initiative

Focusing On Outreach To Enroll And Link Children To Health Care In King County

The Access and Outreach component of the Children's Health Initiative (CHI) provides education about the value of early prevention and insurance coverage. It proactively reaches eligible low-income families and enrolls them in publicly-funded health insurance programs. After enrollment, the CHI links the children to medical and dental homes and provides care coordination in safety net clinics to assure that children receive preventive care and needed follow-up. To address existing disparities in health care access, the CHI's outreach efforts target difficult to reach populations.

Between January 2007 and June 2008, CHI's outreach staff worked with schools, churches, preschools, daycares, family support centers, and immigrant service agencies. CHI provided more than 4,000 community agency staff and 7,000 parents of low-income children with culturally appropriate health education and guidance regarding recommended preventive care, health insurance, and linkage to medical and dental homes.

"I worked with one family with three kids, ages 10, 9, and 5, who had never been to the dentist. The mother had a difficult work schedule and said that the kids had never had any complaints about their teeth. I was able to refer them to a dentist who would see the whole family at the same time. The mother made appointments for all of the children and was surprised to find out that they had cavities. They had not complained because they had grown used to them." — *CHI Health Educator*

Carol Allen, CHI Health Educator, teaches a child how to brush his teeth.

Enrollment and Linkage Results

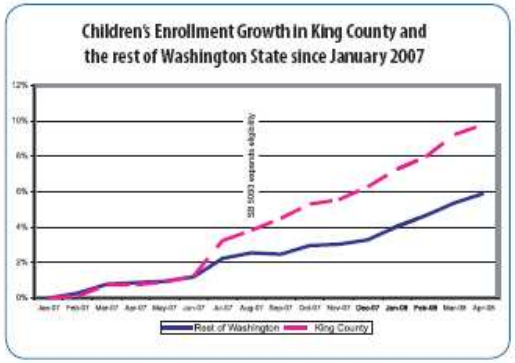
First – CHI helps families get health insurance, because we know that children who have insurance are healthier. King County now leads the state in helping children not only to get covered by insurance but actually to get through the doors to a medical and a dental home and get the services they need.

From January 2007 through June 2008, the CHI has enrolled 2,747 children in coverage.

Between January 2007 and April 2008 (the last month for which the state has data), King County's rate of growth for enrollment has been higher than the rest of the state – 9.8% growth for the county compared to 5.9% for the state.

Second, since we know that many Medicaid enrollees never see a doctor or dentist, CHI focuses on ensuring that the children enrolled have visits with a doctor and dentist, especially for preventive care. Over 83% of the newly enrolled children have seen a doctor as evidenced by data resulting from a ground breaking data share agreement CHI has with the state's Department of Social and Health Services (DSHS).

"A family came in with a boy who had tooth pain for months. The mother had been using home remedies as she had given up on getting Medicaid. She'd been trying for a year to get coverage and just couldn't make it happen. I got them approved for medical coupons within a day, connected to the Neighborcare Health Southeast Dental Clinic the following day, and all the other children in the family covered for medical care as well." *— Application Worker*



Access to this data enables the CHI to evaluate its success in connecting children to care and to identify and follow-up with families whose children have not yet seen a doctor or dentist.

Care Coordination Improves Health

Third, the CHI focuses on improving children's health by contracting for Care Coordinator positions in six safety net clinics. These care coordinators use quality improvement techniques to expand the medical practices' delivery of comprehensive preventive services, remove barriers to care, and ensure children's completion of treatment.

Data from safety net clinics with CHI Care Coordinators indicate increases in children accessing preventive care, particularly in key prevention areas that have been shown to reduce long-term costs such as immunizations and early dental care. For example, Sea Mar Community Health Center reported that its rates of children who are up-to-date on immunizations increased from 49% in 2007 to 88% in 2008.

Valley Family Medicine reported a substantial increase in children with a first oral health visit by age one, from 43% in 2006 to 86% in 2008. Studies have shown that these types of preventive care are both important for children's health and result in long-term avoided health care costs.

Future Measurement and Evaluation

The local commitment of public and private funds to improve children's health has already led to more enrolled children who are obtaining the health care they need. In 2009, health improvement findings such as well-child visit and immunization rates, hospital and emergency room usage, and school days missed due to illness will assess the initiative's success locally and inform statewide efforts to improve the health of our state's next generation.


Pediatrician Kim McDermott talks with a mom and her baby during a Well Child Check visit at Healthpoint Eastside.

"The care coordinator position allows clinics to reach out to families. In the past, they usually would just wait for families to come in. This makes families realize the clinic is more than just a place to go when someone is sick. This is new to many families in whose culture people go to the doctor only when they are ill. We help the families stay well, not just get better. We help them understand what kids need to stay healthy –good nutrition and good snacks, physical activity, preventive care. We also give families the message that mom has to take care of herself so she can take care of her kids." *— Clinic Care Coordinator*

SEPTEMBER 2008

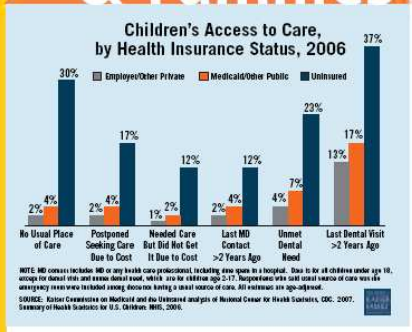
Covering KIDS & Families

For most families, *the back-to-school season is a time for exploring new opportunities, tackling fresh challenges and building on accomplishments. But for families without health insurance, it's a season of anxiety and uncertainty. Lack of health care coverage for children imperils their dreams and limits their potential, and that harms us all.*

For the last nine years, the American Hospital Association and its member hospitals have teamed up with the Robert Wood Johnson Foundation and other national health care organizations to offer assistance and hope to eligible families in need of health care coverage for their children. Every year, thousands of back-to-school events take place nationwide through a network of more than 200 national organizations all working toward one goal – health care coverage for every child. *We are making progress. The State Children's Health Insurance Program (SCHIP) ensures that an estimated 6 million children have access to basic health care. But that still leaves more than 9 million children without access to care. That's too many dreams wasted, and too much potential squandered. And that is why fully reauthorizing SCHIP is so important. We must continue to work together to make health coverage for children as universal as elementary and secondary education, and the Covering Kids and Families initiative is an excellent way to keep moving forward.* *We are pleased to present this special insert, which contains innovative event ideas and success stories from hospitals and health systems nationwide, as well as resources to help you start making a difference for children and families in your community. For even more ideas, visit www.CoverTheUninsured.org.* *We hope this year's insert will be a useful resource to you and your team. On behalf of the AHA Board of Trustees, thank you for your continued leadership and commitment to ensuring that every child has a healthy start and a bright future. Sincerely,*

Richard Umbdenstock, President and CEO
American Hospital Association

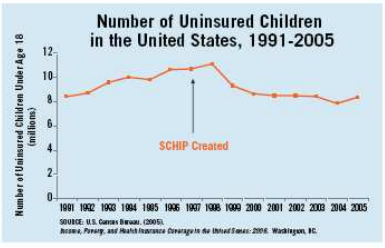
William Petasnick, 2008 Chairman
AHA Board of Trustees

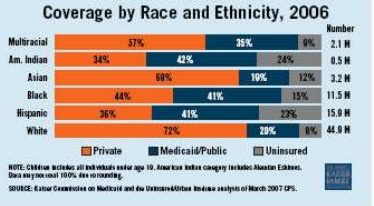


The 10th anniversary of the authorization of the State Children's Health Insurance Program (SCHIP) passed without full reauthorization. The program, vital to millions of U.S. children, was only temporarily reauthorized through March 2009. Although broad bipartisan support exists for SCHIP, Congress and the Bush administration were unable to agree on the future of the program: The administration wanted to scale back the program, while Congress wanted to expand it to reach more low-income children.

Almost immediately upon taking office, the new president, along with Congress, will have to tackle the question of reauthorizing this critical program.

When SCHIP began more than 10 years ago, the number of uninsured children hovered close to 12 million. Today, well over 6 million children get their health insurance through SCHIP, and the number of children going without health care coverage has dropped to 9 million. Over the last 20 years, the number of uninsured has increased by one million annually, and without Medicaid and SCHIP those numbers would have been even higher. The AHA continues to advocate for full reauthorization of the program with funding coming from sources other than cuts to Medicare and Medicaid payments to hospitals.





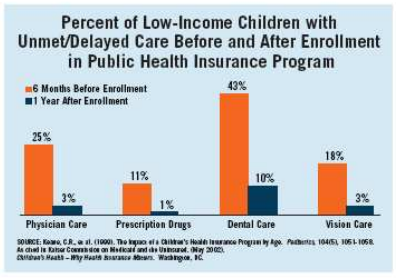
Today, nearly one in nine U.S. children lacks health insurance. These children come from every racial and ethnic background: 23% are Hispanic; 15% are black; 12% are Asian; and 8% are white. Income is a key factor in health coverage. The majority of uninsured children come from working families, with nearly 70% coming from families with incomes no higher than twice the federal poverty level, about $42,000 for a family of four.

Studies show that uninsured children perform more poorly in school than their insured classmates, and can suffer severe health consequences. They are more than twice as likely to go without care for recurring ear infections, which, if untreated, can lead to permanent hearing loss. They are 25% more likely than insured children to miss school and are four times more likely to end up in the emergency department with conditions that could have been avoided. In addition, children without insurance are between three and five times more likely than insured children to have unmet medical needs. Being without health coverage limits a child's ability to grow, thrive and engage in society in a productive way.

The good news: Nearly 75% of the nation's 9 million uninsured children are eligible for either Medicaid or SCHIP – programs that can get them the preventive care they need and get them on the road to success in the classroom, and in life. Studies have found that three-quarters of previously uninsured children no longer had unmet health needs or delayed care after gaining public coverage through SCHIP or Medicaid. Insurance coverage makes a difference in the health of our children, and our communities.

Since SCHIP's inception, the AHA has worked with hospitals, state hospital associations and other national partners to raise awareness of the problem of the uninsured and provide assistance for children and families to enroll in Medicaid and SCHIP. And many hospitals and health systems have led efforts in their communities to marshal resources to provide medical services and promote enrollment in Medicaid and SCHIP.

How can you help? Take a look inside at some of the programs hospitals have sponsored or taken part in to see what you can do to help our nation's children and families.



Hospitals HELPING

Illinois

PROJECT: **1000 Healthy Kids & Families Campaign**
SPONSOR: **Resurrection Health Care**
LOCATION: **Greater Chicago area**
PARTNERS: *Main partners include the Office of the Governor, Chicago Sun-Times, Chicago Public School System, and Chicago Police Department, among others*

Last year, Resurrection Health Care leaders sat down to determine how to drive real change in the communities served by the system's hospitals. They wanted to become a force for change in Illinois and sought to create a coverage initiative that would have a substantial impact on the health of the state's children. The result was the *1000 Healthy Kids & Families Campaign*, which sought to register at least 1,000 eligible children in the state's All Kids insurance program.

Resurrection reached out to partners across the metro Chicago area to create an awareness campaign, culminating in a registration drive on June 21. When identifying partners, Resurrection approached organizations like the Chicago Public Schools system, but also approached non-traditional partners such as the Chicago Sun-Times, the local Catholic parishes and other faith congregations. Resurrection also coordinated three community roundtable forums, moderated by Phil Ponce of *Chicago Tonight*, a local PBS public affairs program. Several Resurrection representatives also met with Chicago City Council members, who ultimately supported the initiative with the adoption of a city resolution.

The drive, which culminated with registration fairs at 41 sites across the Chicago area, was a resounding success, enrolling more than 1,200 children. Gov. Rod Blagojevich presented Resurrection and the Chicago Sun-Times with the Governor's PATH (People Are Today's Heroes) Award for their efforts.

Resurrection's Social Mission Department continues to explore opportunities to work with the Chicago Public Schools to assist with All Kids enrollment as part of its back-to-school programs. In addition, the department is examining the process and consistency of how families and children are enrolled in the All Kids program across Resurrection. Efforts are also underway to establish a better sense of the number of uninsured children residing in the community who are eligible, but not enrolled in the All Kids program.

For more information, please contact Brian Crawford, senior director, system public relations, at (773) 792-6322 or bcrawford@reshealthcare.org.

Massachusetts

PROJECT: **UMass Memorial Ronald McDonald Care Mobile "On the Road to Health and Wellness for Vulnerable Populations"**
SPONSOR: **UMass Memorial Health Care**
LOCATION: **Worcester**
PARTNER: *Ronald McDonald House Charities*

For more than seven years, the UMass Memorial Ronald McDonald Care Mobile has been one of the flagship programs of UMass Memorial Health Care's effort to reduce health disparities. Chosen as the international launch site by the Ronald McDonald House Charities, UMass Memorial Health Care had the experience, infrastructure, and capacity to implement this comprehensive, community-based model of care that includes medical, preventive dental care, outreach services and insurance enrollment to those who need it most: impoverished, undocumented, uninsured and underinsured children and adults who are predominantly from ethnic and linguistic minorities.

The Care Mobile, which began operations in the fall of 2000, is the first mobile unit combining medical, dental and outreach services in New England, providing more than 30,000 patient visits since its inception. The Care Mobile is a 40-foot-long medical and dental office on wheels. It has two examination rooms, wheelchair accessibility, and a dental operatory.

The Care Mobile aims to eliminate disparities by addressing those barriers that impede access to care. Specifically, the program serves as a neighborhood-based, user-friendly point of entry into the health care system, where a coordinated effort connects patients to a permanent medical home for ongoing care. The culturally diverse staff also connects patients to other resources such as food pantries, housing/shelters and referrals to social support services. Services are provided regardless of the patient's insurance status while targeting low-income neighborhoods and schools that have a high percentage of students eligible for the reduced/free lunch program.

In 2007 alone, the Care Mobile provided 10,826 patient visits and close to 19,000 procedures. In 2008, the school-based dental program is targeting 14 elementary schools. Given that the lack of fluoridation in the City of Worcester water supply has contributed to a high rate of tooth decay among children, the Care Mobile Program and its partners are playing a critical role in addressing an unmet community health need.

Where the rubber meets the road, the Care Mobile is the Community Sweeper that connects the underserved to health care.

For more information, please contact Monica Escobar Lowell, vice president, community relations, at (508) 334-7640 or lowellm@ummhc.org.

Ohio

PROJECT: **Cooperative Community CHIPS Registration**
SPONSOR: **St. Rita's Medical Center**
LOCATION: **Allen County**
PARTNERS: *Allen County Health Department, Allen County Health Partners, Lima City Schools*

St. Rita's Medical Center's Neighborhood Nurses go door-to-door, on foot or on bike, making sure the residents of the area's most at-risk neighborhoods get access to the care they need. Since its inception, the program has helped residents monitor their chronic health conditions, get regular health check-ups, get their prescriptions filled, and immunize their children against disease. As a result, twice as many children are getting immunized, fewer people are relying on the emergency department for their primary health care and residents are learning how to make good decisions about their health and the health of their families. The program was awarded Ohio's first Governor's Award of Excellence for its positive impact on the community.

When the state created the CHIPS program in 1998, the Neighborhood Nurses incorporated enrollment into their ongoing health promotion efforts – sharing literature about the program, helping eligible families fill out paperwork, and doing whatever was necessary to fill in other gaps, such as a lack of affordable transportation, to help residents access services and get the care they need. They also partnered with the school system to raise awareness of the program, hosting school-based events such as registration days and health fairs, and providing information to parents through fliers and school newsletters.

In addition, a designated financial counselor contacts all families with uninsured children who seek services at St. Rita's Medical Center and St. Rita's MedCare Clinic for low-income residents, as well as the hospital's Urgent Care Centers and Ambulatory Care Centers. Neighborhood Nurses work with the financial counselors to do follow-up when possible.

For more information, please contact Linda Chartrand, director, media relations and external communication, at (419) 226-9802 or lechartrand@health-partners.org.

Pennsylvania

PROJECT: Insuring Delaware County's Children Today
SPONSOR(S): Crozer-Keystone Health System, Mercy Fitzgerald Hospital and Riddle Memorial Hospital
LOCATION: Delaware County
PARTNERS: *This county-wide coalition is comprised of many competitors – health systems and health care providers, insurance companies, government agencies, and businesses – who are able to work together under the banner of the Delaware County Chamber of Commerce to focus on this important county health issue. The coalition partners closely with the Pennsylvania Department of Insurance (DOI) and the Pennsylvania Childrens Health Insurance Program (CHIP) to enroll children either in low-cost or free health insurance.*

Led by co-chairs Jeffrey Vermeulen, president of the Delaware County Chamber of Commerce, and Gerald Miller, a senior executive at the Crozer-Keystone Health System, the Insuring Delaware County's Children Today coalition pools the talents and resources of its members to develop and execute communication, outreach and education strategies. The collaboration has proven successful with increases in enrollment, with many months exceeding 25% over previous years. The coalition can point to the enrollment increase of 2,700 children (about 100 children per month) in the past 2.5 years in CHIP. Additional children were enrolled into Medical Assistance due to family income.

The coalition has found it helpful to work closely with the DOI and CHIP for guidance, resources and outreach materials. It also works closely with local, state and federal legislators to secure communication and education outreach opportunities and support, and to advocate for simplification of the enrollment process and expansion of income eligibility requirements for state-funded insurance.

Some recent projects include: in-depth programs with selected schools to work with family outreach and enrollment; developing public service announcements on local, municipal, county and school district television channels; developing and distributing informational placemats in area diners and restaurants during the summer months; training county employees to assist with enrollment in the family court system; working with agencies that provide tax preparation aid to assist with enrollment for families of uninsured children; offering outreach in county libraries; and sponsoring ongoing community health education programs offered by hospital and doctor group coalition members.

For more information, please contact Susan Bradley, administrative director, managed care, Crozer-Keystone Health System, at (610) 338-8200 or Sue.Bradley@crozer.org.

Washington

PROJECT: King County Children's Health Initiative
SPONSOR: King County
LOCATION: King County
PARTNERS: *Group Health Cooperative, Washington Dental Service, Children's Hospital and Regional Medical Center, Community Health Plan, Evergreen Healthcare, First Choice Health, Harborview Medical Center, King County Health Action Plan – Public Health – Seattle & King County, Molina Healthcare of Washington, Northwest Hospital & Medical Center, OneHealthPort, Providence Health & Services, Retailigent, Robert Wood Johnson Foundation, Swedish Medical Center, United Way of King County, University of Washington Medical Center, Valley Medical Center, Virginia Mason Medical Center, WK Kellogg Foundation, Washington State Hospital Association*

Washington state's 2007 "Children's Health Care Act" expanded coverage to all children in families earning less than 250% of the federal poverty level in July 2007 and to families earning less than 300% in January 2009. With the new coverage, it became more important than ever for local efforts to sign families up and make sure that expanding health coverage leads to improvements in children's health.

In May 2007, the King County Council passed a motion to adopt the Children's Health Initiative (CHI), a local approach to improving the health of low-income children. The program is a true public-private partnership that goes beyond enrollment to ensure each enrolled child has a medical and dental home. The county's $3 million investment has drawn equal size contributions from Group Health Cooperative and the Washington Dental Service, and additional contributions from 17 local and national organizations totaling $3 million.

To reach as many children as possible, CHI employs a variety of techniques, relying heavily on staff who reflect the diversity of the population. It trains volunteer "promotoras" in the local Latino community and contracts with community health workers in the East-African, Asian and Russian-speaking communities to help spread a grassroots message about the importance of insurance and preventive services. These staff members also help families access health care services. Teams of health educators, application workers and community health workers are able to reach more geographic areas and isolated communities than previously possible.

King County now leads the state in helping children not only to get covered by insurance but actually get through the doors to a medical and a dental home and get the services they need. Through June 2008, CHI enrolled or renewed coverage for over 2,700 children. Since many Medicaid enrollees never see a doctor or dentist, CHI focuses on ensuring that the children enrolled schedule visits, especially for preventive care. As a result, more than 83% of the newly enrolled children have seen a doctor. Over 4,000 community agency staff and 7,000 parents have received training or education on the need for preventive services and how to access them.

For more information, please contact Susan Johnson at (206) 263-8684 or Susan.Johnson@kingcounty.gov.

Covering KIDS & Families

RESOURCES

Questions about what to do and how to do it? Trying to determine the best way to reach out to uninsured populations? These Web sites can help you develop outreach and enrollment events.

- **Agency for Healthcare Research and Quality**
  www.ahcpr.gov/chip
  Provides SCHIP information on topics such as target population, outreach and enrollment, benefit design and service delivery, cost-sharing, and monitoring and evaluation.

- **American Academy of Family Physicians (AAFP)**
  www.aafp.org/online/en/home/policy/state/issues/schip.html
  Provides an overview of SCHIP, as well as links to state and federal resources and advocacy organizations.

- **American Academy of Pediatrics**
  www.aap.org
  Focuses on SCHIP resources for the health, safety and well-being of infants, children, adolescents and young adults.

- **American Public Health Association (APHA)**
  www.apha.org
  Includes a backgrounder on SCHIP and examples of SCHIP advocacy efforts from APHA state affiliates.

- **Association of Maternal & Child Health Programs (AMCHP)**
  www.amchp.org
  Identifies the issues relevant to managed care, Medicaid, SCHIP and other health service delivery networks and also monitors the impact of welfare reform on Medicaid, SCHIP and maternal and child health programs.

- **Centers for Medicare & Medicaid Services**
  www.cms.hhs.gov/schip
  Provides materials on SCHIP including state plans, enrollment, outreach, and regulations and allotment notices. State Medicaid toll-free phone numbers can be found at www.cms.hhs.gov/medicaid.

- **Center on Budget and Policy Priorities: Start Healthy, Stay Healthy**
  www.cbpp.org/shsh/index.html
  National outreach campaign, supported by community-based organizations, health services providers, advocacy groups, program administrators and others, which identifies eligible children and families for free or low-cost health insurance programs.

- **Community Voices: Healthcare for the Underserved**
  www.communityvoices.org
  Healthcare for the Underserved, a multi-year initiative funded by the W.K. Kellogg Foundation, seeks to improve access to quality health services. Grassroots activities give uninsured and underinsured a voice to help make health access and quality part of the national debate.

- **Cover the Uninsured**
  www.CoverTheUninsured.org
  An annual campaign sponsored by the Robert Wood Johnson Foundation aimed at increasing the overall number of individuals with health coverage. The site provides information on the uninsured and suggestions for sponsoring coverage events in your community.

- **Cross Cultural Health Care Program (CCHCP)**
  www.xculture.org
  CCHCP examines the broad cultural issues that affect the health of individuals and families in ethnic minority communities nationwide. The site has translated materials, training programs, resources and other materials to assist in outreach activities to minority populations.

- **Families USA**
  www.familiesusa.org
  A national non-profit, non-partisan organization dedicated to achieving high-quality, affordable health and long-term care for all Americans. The site provides information on Medicaid and SCHIP, federal health issues and specific state issues.

- **GovBenefits.Gov**
  www.govbenefits.gov/govbenefits/index.jhtml
  GovBenefits.gov is a partnership of federal agencies with a shared vision – to provide improved, personalized access to government assistance programs. The site's online screening tool helps identify government benefit programs for which citizens may be eligible, along with information on how to apply.

- **Health Resources and Services Administration (HRSA)**
  www.mchb.hrsa.gov/
  The Maternal and Child Health Bureau, a division of HRSA, works specifically to help women and children gain access to better, more comprehensive care.

- **Insure Kids Now!**
  www.insurekidsnow.gov
  Insure Kids Now!, a federal campaign to link the nation's uninsured children to free and low-cost health insurance, provides state-specific eligibility information and examples of successful outreach efforts for states, community-based organizations and other interested parties. Hotline: (877) 543-7669.

- **Kaiser Family Foundation**
  www.kff.org
  Researches and provides information on today's major health care policy issues. The Web site includes information about Medicaid and SCHIP across the nation, and comparative state and national statistics.

- **National Association of State Health Policy**
  www.nashp.org
  Serves as a guide to the SCHIP program; searchable by state.

- **National Association of State Medicaid Directors (NASMD)**
  www.nasmd.org
  Serves as a focal point of communication between the states and the federal government, and provides an information network among the states on issues pertinent to the Medicaid program. Also, provides up-to-date materials regarding each state's Medicaid and SCHIP programs.

- **National Conference of State Legislatures**
  www.ncsl.org/programs/health/chiphome.htm
  Comprehensive state policy Web site provides information and reports on Medicaid and SCHIP, and access to more than 500,000 state documents encompassing legislative policy reports, legislation, statutes and national state surveys.

- **National Governors' Association (NGA) Center for Best Practices**
  www.nga.org
  NGA, a bipartisan national organization of the nation's governors, and its Center for Best Practices provide reports on health insurance coverage and costs trends; state "best practices" models to increase health insurance coverage and contain costs; and other information.

- **State Coverage Initiatives**
  www.statecoverage.net/matrix/waivers.htm
  Provides a comprehensive list of Medicaid and SCHIP waivers by state.

- **U.S. Department of Health & Human Services (HHS)**
  www.os.dhhs.gov
  Provides extensive information for both children and families on available health care coverage. Also, the site provides information specific to each state program as well as guidelines on eligibility and other facts.

H. Online Enrollment Materials

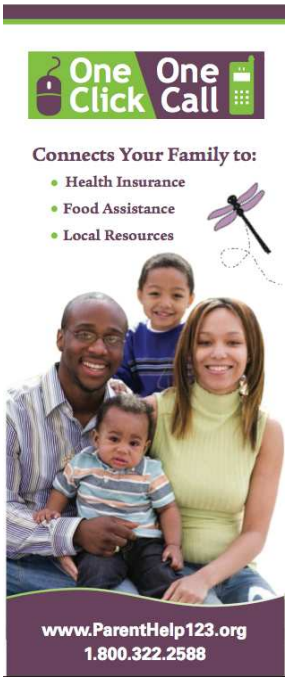
I. KUOW's Weekday with Steve Scher Podcast

A WithinReach Outreach Specialist was interviewed by Steve Scher on NPR's Weekday Talk Radio show on February 6, 2009 about the economic downturn and its impact on families in Washington. Her interview highlighted how to access state benefits like health insurance and food stamps through ParentHelp123.org and the Family Health Hotline. Solid Ground spoke about access to food through Seattle food banks. Immediately following the interview calls came into the Family Health Hotline.

II. KCTS TV – Tough Times: Rising Above the Financial Crisis Interview

Based on the KUOW radio interview, a producer from KCTS TV contacted WithinReach about participating in a series they were planning about the economy, Tough Times: Rising Above the Financial Crisis. WithinReach is represented in the video section with an interview about WithinReach and is also listed as a resource under their Parent Resources section.

III. New "One Click – One Call" outreach materials highlight WithinReach's integrated services through ParentHelp123.org and the Family Health Hotline.



IV. Screen shots of ParentHelp123.org home page in English and Spanish

ParentHelp123 A Program of WithinReach

Connecting families with *food and health resources*

THURSDAY DECEMBER 4, 2008

Be more effective in your work with families, stay up to date on information about state-sponsored health insurance and food resources in Washington state with What's New for Professionals.

More children are eligible for "WA Apple Health For Kids"!

In January 2009, families earning up to 300% of the Federal Poverty Level may be eligible for children's health coverage that includes medical, dental, vision and mental health benefits for children under age 19.

- Review the new income guidelines
- Review the new premiums for low-cost coverage
- Apply online using the new 300% guidelines
- "Apple Health for Kids" Applications (Fill in or print in multiple languages)

Help children keep continuous coverage with a new easy renewal form!

The NEW Renewal Form for "Apple Health for Kids" and Family Medical provides a simple way for families to verify they still qualify for state benefits each year.

- No signature required - fill out on behalf of your clients
- Fill-in / Print / Send / to the local DSHS Office
- Questions - call the local DSHS Office or Medical Assistance Customer Service 1-800-562-3022

NEW Outreach Materials!

www.ParentHelp123.org Wallet Cards are available to promote online access to free and low-cost health insurance, food assistance and local resources.

- Available in English and Spanish
- Colorful, convenient size

Order these FREE Materials today! »

WithinReach
essential resources for family health

ParentHelp123.org is a program of WithinReach, www.withinreachwa.org

For more information, visit http://www.parenthelp123.org/ or contact Sue Waldin, Outreach Specialist suew@withinreachwa.org or 206.830.7646

Please forward this resource to colleagues who work with families!

ParentHelp123 Un Programa de WithinReach

English | Iniciar sesión | Acerca de ParentHelp123 | Contacto

RECIBIR BENEFICIOS | RECURSOS | EMBARAZO | RECIÉN NACIDO | FAMILIAS | PROFESIONALES

Conectando a usted y su familia con
recursos de salud y alimentos

¡Características nuevas!

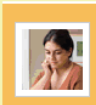
¡Solicite por internet para
Alimentos y Seguro Médico
utilizando el BenefitFinder!

- Enviaremos su solicitud
- Disponible en español

Solicite hoy

WithinReach
essential resources for family health

ParentHelp123.org ayuda a familias solicitar para programas estatales de seguro médico y alimentos, y ayuda encontrar servicios en su comunidad. ParentHelp123.org es administrado por WithinReach. » Aprenda más



Manténgase informado(a) sobre influenza H1N1

Aprenda más sobre que puede hacer para proteger a su familia y mantenerse saludable

Información sobre desempleo

Averigüe si es elegible y solicite por internet

Enlaces

- Bajar Solicitudes
- Su oficina local de DSHS
- Seguro médico
- Resource Finder
- WIC

¡Llámenos para ayuda por teléfono!

- La línea de Family Health: 1-800-322-2588
- Ayuda está disponible en varios idiomas

¡Solicite para alimentos & seguro médico hoy!

¡Solicite hoy!

Averigüe si es elegible para beneficios estatales como:

- Seguro médico para niños (Medicaid, S-CHIP)
- First Steps (seguro para un embarazo)
- Seguro médico de Basic Health
- Basic Food (estampillas de comida)
- WIC

¡Solicite por internet para su familia hoy!

Socios de WithinReach:

GroupHealth | BOEING | WIC | Washington State Department of Health | GREATER EVERETT COMMUNITY FOUNDATION Serving all of Snohomish County | Basic Health | DELTA DENTAL Washington Dental Service Foundation | CHI Children's Health Initiative

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I. KC Kids Dental Report

KC KIDS

KING COUNTY KIDS

CHILDREN'S ORAL HEALTH PROGRAM

Program Report

KC KIDS
2008 Program Report

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KC KIDS
Introducing the Program

Overview

The King County Kids (KC KIDS) Children's Oral Health Program was one of three pilot programs launched as part of the Children's Health Initiative (CHI), created in 2007 by King County Executive Ron Sims in collaboration with Seattle & King County, the State of Washington, Washington Dental Service, Group Health Cooperative, and a diverse range of private funders and community-based organizations. The Children's Health Initiative's mission is to help ensure that low-income families benefit from federal and state health insurance programs, and the KC KIDS dental program made valuable strides toward supporting that goal. This pilot program, which ran throughout 2008, focused on increasing low-income families' access to preventive and primary dental care. The KC KIDS Dental Program successfully delivered services to over 800 children in cities all across King County, WA.

Moving Ahead to "Cover All Kids"

In addition to supporting needy families around Puget Sound, the KC KIDS 2008 pilot program was designed to assist the State of Washington in preparing for the 2009 expansion to the Cover All Kids law, which funds health insurance programs for low-income families. In January 2009, this law increases the number of families who are eligible for publicly-funded health care coverage by raising the income limit to families earning less than 300% of the federal poverty level (FPL). To serve as a demonstration for the 2009 expansion of coverage, Washington Dental Service provided a $1 million dollar grant to fund a pilot program that ran throughout 2008. The KC KIDS program targeted families with income between the 250% and 300% FPL (about $60,000 per year for a family of four), which represented over 1,000 potentially eligible families in King County who could benefit from receiving no-cost dental care for their children.

How the KC KIDS Program Worked

To provide greater simplicity and ease for providers, patients and the State, Washington Dental Service (WDS) assumed responsibility for development, marketing, administration, and evaluation of the countywide KC KIDS dental coverage program. The project was led by WDS Vice President and Dental Director, Ron Inge, DDS and Project Manager Darlene O'Neill, and supported by numerous community partners.

The KC KIDS team successfully launched and managed the program as follows:

- Program Guidelines — Required that eligible families live in King County; have children under age 20; meet income guidelines; and access a Washington Dental Service PPO provider.
- Outreach — Hired two outreach workers; developed marketing media to promote the program; and conducted extensive outreach efforts in schools, libraries, community centers, media outlets, local businesses and more.
- Website — Produced a KC KIDS website (external and independent of the WDS/Delta Dental website) where families could learn about the program, use an online tool to determine eligibility, and download enrollment applications in multiple languages. [www.kckidsdental.org]

- Enrollment — Produced and distributed enrollee materials including a program handbook and provider directory that listed, by city/zipcode, over 900 participating dentists in the Washington Dental Service PPO Provider Network.
- Customer Service — Hired a third party administration company to provide customer service phone support to address program inquiries and eligibility questions.
- Claims Processing — WDS leveraged their streamlined system to support providers with prompt processing of claims and reimbursements. The KC KIDS program was set up in the WDS system similar to their other plans, and PPO providers received 100% of their contracted fees for participating in this program.

Overcoming Outreach Challenges

As the KC KIDS pilot program targeted families with income in the specific range of 250% to 300% FPL, the WDS/KC KIDS team faced a considerable challenge in finding eligible children. To bolster their efforts to locate and enroll children, they developed and employed outreach strategies that focused heavily on schools, the Internet, child care centers, community organizations, pediatricians, radio and television.

A second challenge for the pilot project was the one-year time frame, which meant a quick start-up period in order to ensure that children were located, enrolled, and accessed services prior to the end of 2008. Through smart planning and a motivated, creative team, the KC KIDS website was launched on time despite an aggressive schedule, providing an Internet access point for the program in less than three months. Furthermore, throughout 2008, the WDS/KC KIDS team worked hard to ensure that children accessed services after enrollment, sending quarterly letters to enrolled families to encourage them to make a dental appointment.

Lessons Learned & Opportunities

In terms of treatment, despite early assumptions that enrolled children would require extensive restorative procedures, it was promising to see that a high percentage of the dental care provided was preventive in nature.

From a coverage perspective, the WDS/KC KIDS team discovered an important eligibility gap for children under 250% FPL in that families who have employer-based medical insurance are not eligible for any federal dental coverage (SCHIP). Health Innovation Implementation Commitee members have advocated with federal government officials to allow dental wrap-around services for SCHIP-eligible children who have privately funded medical insurance.

In 2009, laws have been enacted to extend medical and dental coverage, and SCHIP has approved the wraparound services for dental care, improving access to care for 10 million children nationwide.

For families whose income was too low to qualify for the KC KIDS program, the WDS/KC KIDS enrollment team connected them with other services, referring 977 under-income children to CHI outreach teams. In turn, the Children's Health Initiative teams referred children to the KC KIDS program as well.

KC KIDS Success Highlights

The 2008 KC KIDS Children's Oral Health Pilot Program was a tremendous success, thanks to the KC KIDS team at Washington Dental Service (WDS). Their extensive outreach efforts and well-organized program administration brought dental care services to over 800 children from low-income families in cities throughout King County, WA. Program highlights include:

High Enrollment

The KC KIDS pilot program enrolled 808 of the originally estimated target population of 1,000 eligible families between 250% - 300% FPL. By June 2008, KC KIDS had already enrolled 500 children. Families were required to see one of nearly 950 WDS Participating PPO Providers in King County, and 739 of those dentists were accessed for services.

Extensive Outreach

To effectively locate and enroll eligible children, the KC KIDS team conducted a wide range of outreach activities primarily centered on distributing 650,000 flyers throughout King County. They distributed flyers to nearly every school district in King County twice during the year and at the schools' summer lunch programs. They also handed out KC KIDS-branded toothbrushes and pencils at the schools. Additionally, the team delivered KC KIDS flyers and posters to hundreds of child care providers, community agencies such as YMCA and Boys and Girls Club, libraries, hospitals and doctor's offices, and numerous local businesses.

Creative Marketing Management

To educate the public and help facilitate a smoother enrollment process, the KC KIDS team developed a website [www.kckidsdental.org] that provided interactive tools and downloadable forms to help families easily determine their eligibility and get started with an enrollment application. By December 31, 2008, the website had received over 17,000 visits. Additionally, from January to September 2008, a paid and PSA radio spot broadcasted information about the KC KIDS program; and in March 2008, King5 News spotlighted KC KIDS on a health-related television segment, followed by an article and video on their website.

Effective Community Partnerships

The WDS/KC KIDS team worked closely with Public Health Seattle & King County (PHSKC) to inform the community about the program and PHSKC staff helped promote the program in school-based health programs. Additionally, Seattle Department of Social & Health Services (DSHS) spread the word through its network, and Child Care Resources widely distributed program information to networks of child care agencies and care givers.

83% Utilization of Services

808 Children Enrolled

739 Dentists Accessed

650,000 Flyers Distributed

Over 17,000 Website Visits

9 Months of Radio PSAs

Spotlighted by King5 News

15 PHSKC Nurses Helped

Leveraged DSHS & Child Care Networks

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KC KIDS

Managing Promotion & Outreach

Overview

With the KC KIDS Children's Oral Health Pilot Program, the primary goal was to get the word out to needy, eligible families in cities throughout King County, WA and help them get their children into a dentist during 2008 to receive the care they need. To make this happen, the KC KIDS team at Washington Dental Service (WDS), along with multiple community partners, engaged in a highly successful campaign to promote the dental care coverage program using numerous strategies, including print media and the Internet, public outreach, media coverage, and as much word-of-mouth referral as possible.

Flyers & Posters

The KC KIDS program was advertised in cities all across King County with the help of colorful flyers and posters, which promoted the key benefits of the program, eligibility requirements, and contact points for getting started toward enrollment.

During 2008, 650,000 flyers were distributed, with the greatest impact in schools throughout King County. Once the WDS/KC KIDS team obtained approval from a school district to distribute flyers, they visited school assemblies and met with nurses to ensure each child was sent home with a flyer. The team delivered flyers to most every school district twice during the school year and also during the summer months to the school lunch programs.

To further increase visibility for the program, the KC KIDS flyer was also produced in a larger poster format and distributed to many community sources such as libraries, medical offices, child care centers, local businesses and others.

KC KIDS Flyer - Full size on page 7

WDS Outreach Letters

To help raise awareness and motivate participation in the program, Dr. Ronald Inge, Dental Director and Vice President at Washington Dental Service (WDS) and project leader for the KC KIDS dental program, sent a letter to all dentists in the WDS PPO Provider Network to educate them about the program and motivate them to share the information with their patients and others who might benefit. The WDS/KC KIDS team also sent an announcement to all WDS employees, promoting the KC KIDS program and encouraging people to spread the word with family, friends, and across their community.

Additionally, to help motivate enrolled children to take advantage of dental the no-cost services throughout 2008, the WDS/KC KIDS team sent quarterly reminder letters encouraging families to schedule dental appointments.

Community Outreach

The WDS/KC KIDS team promoted this dental program at a wide range of locations throughout the region, providing flyers and posters, as well as KC KIDS-branded toothbrushes and pencils, to schools, child care centers, libraries, and many local businesses.

Schools were the most successful outreach strategy. Families that enrolled in the program most frequently reported that schools were how they heard about it, followed by radio, then families and friends. With diverse outreach efforts, people also learned about KC KIDS on the Internet, at dental offices, and local community centers and churches.

In King County, over 64% of the children eligible for free lunch programs had cavities; 27% had untreated decay and 29% of the kids had rampant caries.

- 2005 Smile Survey
King County Public Health

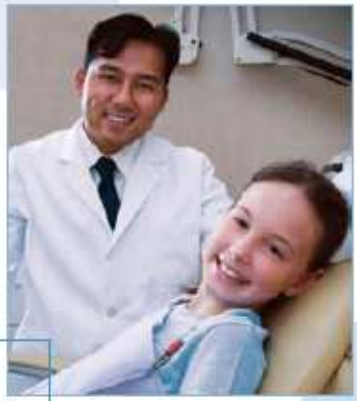
Media Outreach

The KC KIDS program was also promoted on local radio and TV stations. A special highlight came in March 2008, when King5 anchorwoman Jean Enerson featured KC KIDS on her "HealthLink" news segment, followed by an article and video coverage available on the King5.com website.

Additionally, in the summer of 2008, inserts about the program went out to an estimated 300,000 subscribers to Sound Publishing's newspapers in smaller communities.

"School-based dental sealant programs offered by King County Public Health significantly increase the chances that children will get the protective benefits of dental sealants."

- 2005 Smile Survey
King County Public Health



KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

Dental Care for Kids in King County!

The KC KIDS program provides dental care coverage, at no cost, to children who qualify. You are likely to be eligible if:

- ❑ You live in King County, Washington.
- ❑ Your children are under the age of 20.
- ❑ Your income meets certain guidelines.
- ❑ Your children have no other dental coverage.

Enroll Today!

Website: www.kckidsdental.org
Call us: (866) 839-9466
MON - FRI, 6 AM to 6 PM

Special Program for 2008!

Enroll Today! The KC KIDS program runs from January 1 to December 31, 2008. In January 2009, families will need to apply for benefits through the state of Washington.

Helping Community Kids

KC KIDS is a King County children's oral health pilot program, supported by a $1 Million gift from Washington Dental Service.

Family Size	Household Monthly Income*
2	$2,852 - $3,423
3	$3,577 - $4,293
4	$4,308 - $5,163
5	$5,027 - $6,033
6	$5,752 - $6,903
7	$6,477 - $7,773
8	$7,202 - $8,643
9	$7,928 - $9,513
10	$8,653 - $10,383

*** Income Guidelines**

If your income is below these guidelines, contact Community Health Access Program to learn about other programs. Call (206) 296-4841 or visit www.whf.org/programs/chap.aspx.

January 2008

Dear Washington Dental Service Member Dentist:

We are pleased to announce a new Delta Dental PPO group. Beginning January 1, 2008, Washington Dental Service is launching a pilot program that will expand access to dental coverage to uninsured children in King County. This effort is part of WDS's ongoing commitment to improve oral health throughout our state.

The new oral health program is called King County Kids Program (KC Kids). Uninsured children enrolled in this program will be eligible for care from Washington Dental Service member dentists who participate in our Delta Dental PPO network. WDS member dentists who treat children enrolled in the program will be reimbursed for services based on their approved PPO filed fees.

The KC Kids program is part of the Children's Health Initiative, a partnership formed this year between Washington Dental Service and King County to extend dental coverage to children in King County who are not covered by dental insurance.

Here are some of the specifics about the KC Kids program:

- To be eligible for the program, children must be residents of King County, under 20 years of age and not covered by dental insurance.
- The KC Kids program will be administered by Washington Dental Service; all claims will be processed by WDS.
- Eligibility and customer service questions will be handled by EBMS.
- To check on an enrollee's benefits, call EBMS at 1-866-839-9466.
- WDS will issue identification cards to all enrollees. The group name, KC Kids, will be printed on the card.
- The program will use alternative ID numbers, instead of Social Security numbers. These will also be printed on the ID cards.

The KC Kids pilot program will be in effect from January 1, 2008, through December 31, 2008.

If you have families in your practice that live in King County and whose children are not covered by a dental insurance plan and may qualify for this program, please refer them to the special KC Kids Web site for enrollment information: www.kckidsdental.org. They can also call EBMS at 1-866-839-9466 for program information.

We look forward to partnering with you to provide children in King County with the services they need to maintain optimal oral health.

Sincerely,

Ronald Inge, D.D.S.
Dental Director and Vice President, Professional Services

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WDS — Helping Kids in our Community

Washington Dental Service, in partnership with the King County Children's Health Initiative, has launched an oral health pilot program for 2008 that provides dental care at no cost to children in King County whose families are uninsured and whose income is between 250 percent and 300 percent of the poverty level. The program is called KC Kids. WDS has committed $1 million to this program, with the goal of improving the delivery and coverage of oral health services to under-served children.

Sponsorship of the KC Kids program is just one more way that Washington Dental Service is fulfilling its mission to make affordable oral health care available to everyone in Washington state. Throughout 2008, Washington Dental Service will work to raise awareness and participation in the pilot through innovative outreach to local schools, churches, day care facilities and other resources in King County.

To provide dental services for under-served children, the KC Kids program is utilizing Washington Dental Service's Delta Dental PPO provider network in King County, which consists of 949 participating dentists. Participating dentists are reimbursed for services based on their approved PPO fees with WDS.

EBMS, the administrator of Washington Dental Service's employee benefits program, is partnering with WDS for KC Kids. It is providing third-party administrative services to assist with eligibility and enrollment for qualified families.

WDS is committed to making this program a success and a model for future projects that assure that no child goes without proper oral health care. Beginning in 2009, the governor's new Medicaid bill will require the state to include these children in its oral health care coverage program.

WDS encourages everyone to get the word out about KC Kids. To find out more, please visit the KC Kids Web site at www.kckidsdental.org.

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King County children eligible for free dental care

03:57 PM PDT on Saturday, March 15, 2008
By JEAN ENERSEN / KING 5 News

SEATTLE - Half of the children in King County do not get the dental care they need. Now a new program is helping to change that.

When her family lost dental coverage through her employer this year, Kathy Overhus was worried. "We just paid cash for the dental appointments so we limited what we did," she said. She was surprised to learn her family was eligible for a program that could provide the kids free dental care.

First they had to meet some guidelines.

Families must live in King County and have no dental coverage. It's for children younger than 20 whose families earn between 250 and 300 percent of the federal poverty level. That's around $61,000 a year for a family of four.

It sounds high, but families with lower income may qualify for state aid. "We don't make so little that we qualify for more help. But, the situation that we're in, we're not making enough and getting the benefits that we need," Overhus said.

Dentist Dwight Cottrill says that often puts families he sees in a dilemma. "They seem to bring their kids in fairly regularly," he said. "I think probably more than themselves. It's probably kids first, mom and dad last."

Washington Dental Service, the biggest dental insurer in the state, is sponsoring the program with a $1 million grant. Families can choose from more than 900 dentists.

The program provides children with everything from cleanings to fillings, fluoride and sealants at no cost. "We just stepped in to bridge this gap until 2009 so that the children could receive services," said Darlene Oneill, of Washington Dental Service.

In 2009 the state is expected to begin covering these families for the long run. Until then these children can get everything from cleanings to fillings, fluoride and sealants at no cost. The new dental program is one part of King County's Health Action Plan. The goal is to provide regular doctor and dental care for low income children. 150 children are signed up with the dental program so far. Organizers hope to reach at least 1,000 this year.

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SnoValley STAR.com Weekly news for the citizens of North Bend and Snoqualmie, WA

Dental insurance, one tooth at a time

August 13, 2008
By Laura Geggel

Nine-year-old Devin Ramos has visited the dentist three times in two months this summer. Before that, he hadn't seen a dentist in about four years.Devin's mother, Regan Ramos, said she values dental health. When her sister told her about KC Kids, a program offering medical care to uninsured King County residents age 20 and younger, she signed Devin up for a dental checkup.

"He was a little scared at first," said Ramos. "But after he talked to them, he said, 'That was easy.'"

Devin Ramos shows off his teeth after receiving dental care through the Children's Health Initiative.

Last year, about 7,000 children in the county didn't qualify for some type of private or public dental insurance. To help combat the problem, the Washington Dental Service, a Seattle nonprofit with 2,200 dentists statewide, gave the county $1 million. The program is part of King County Executive Ron Sims' Children's Health Initiative, aimed at providing regular doctor and dental care for children of low-income households.

The program runs through Dec. 31, 2008. Once enrolled, children are covered for the remainder of the year. In January, families will need to apply for benefits through the state. Devin, a student at Snoqualmie Elementary, has used the program to fill some cavities. His mother, a caregiver at North Bend's Red Oak Retirement Residence, recently acquired insurance through her job, but "they said since I just got insurance, I'll still qualify until December," she said.

To qualify, families must live in King County and have no dental coverage. The program is for families earning between 250 percent and 300 percent of the federal poverty level. That's $4,308 to $5,163 monthly for a family of four. Families with income below KC Kids' standards can qualify for other dental programs. The program provides everything from cleanings to fillings, fluoride and sealants at no cost.

Project Manager of Washington Dental Service Darlene O'Neill commended the Snoqualmie Valley School District for helping her spread the word about KC Kids by sending flyers home with students. "Not every school district is that receptive," O'Neill said.

As of June 15, 445 children have enrolled in KC Kids for dental care. Dentist Kelly Garwood in North Bend accepts youth from KC Kids, but has yet to have anyone apply for her services through the program.

[continued...]

A state survey conducted in 2005 found that the rate of tooth decay among Washington children is growing with one in five elementary school-aged children having rampant untreated decay - cavities in seven or more teeth. Right about the time junior is blowing out the candles at his first birthday party, he should be making his first visit to the dentist.

The American Academy of Pediatric Dentistry and the American Dental Association recommend that children have their first dental visit by their first birthday, said Dr. Joel Berg, chair of the University of Washington Department of Pediatric Dentistry.

"The main message essentially is this is a preventable disease," he said. "Left untreated, tooth decay can have a significant and dramatic effect on a child's life."

Nationwide, nearly 28 percent of children ages 2 to 5 had at least one cavity, according to a federal survey covering 1999 to 2004. That represents a 4 percent climb from the previous survey, 1988 to 1994, and the first significant statistical increase in 40 years. The federal government first assessed tooth decay in the 1960s. After massive efforts to put fluoride in tap water led to declining cavity rates in the 1970s, tooth decay among preschoolers leveled off in the 1980s - until now.

Poor diet, poor dental hygiene and lack of fluoridated water are among the reasons cited for the increase in pre-school cavities, Berg said.

"Poor dental health is almost always preventable," he said.

Dental disease impacts children of color at a significantly higher rate than white children. In King County, while the rate of caries experience in white children appears to be 37%, that number jumps to 67% for Asian children, 58% for Hispanic, and 55% for African American children.

- 2005 Smile Survey
King County Public Health

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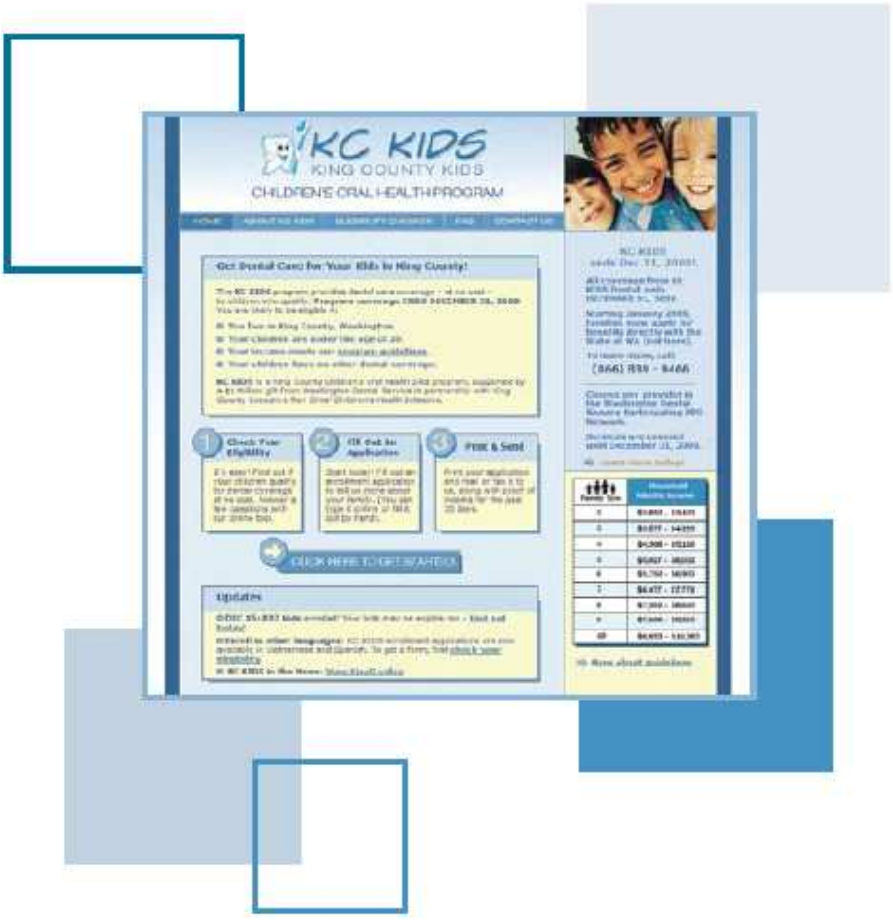

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM
Get Dental Care for Your Kids in King County!
(866) 789 - 9466
CLICK HERE TO GET STARTED!
Updates

KC KIDS

Developing the Website

Overview

A key element for promoting this dental pilot program was the KC KIDS Children's Oral Health Program website [*www.kckidsdental.org*], which served as a central information resource about the program and provided tools to assist interested families in getting started toward enrollment. The WDS/KC KIDS team worked closely with their marketing communications partner, Gavin James Consulting [*www.gjamesdesign.com*] to identify the required feature set, set up web hosting, and define strategies for quick and cost-effective implementation.

The KC KIDS website, which was developed and hosted externally and independent of the Washington Dental Service website, successfully achieved the following important goals:

- Ensure quick development and efficient launch — As much of the logistical planning for the KC KIDS pilot program took place during Fall 2007, the team had an aggressive deadline for planning and developing a website that would effectively support the needs of the program and be ready before January 1, 2008. The team successfully planned, designed, and developed the site within two months, having everything ready by early December 2007. This early completion date allowed the website to support the team's advance outreach efforts already underway in December 2007, which were directing people to the new site.

- Enable users to check their eligibility — Although the team decided they did not want to manage enrollment processing through the website, they did want the site to enable families to determine their potential eligibility and obtain enrollment applications. As such, the website provided an interactive "Eligibility Checker" tool: visitors could enter contact, family, and income information, and the tool would determine their eligibility based on county, age of children, and whether or not they met the income level requirements.

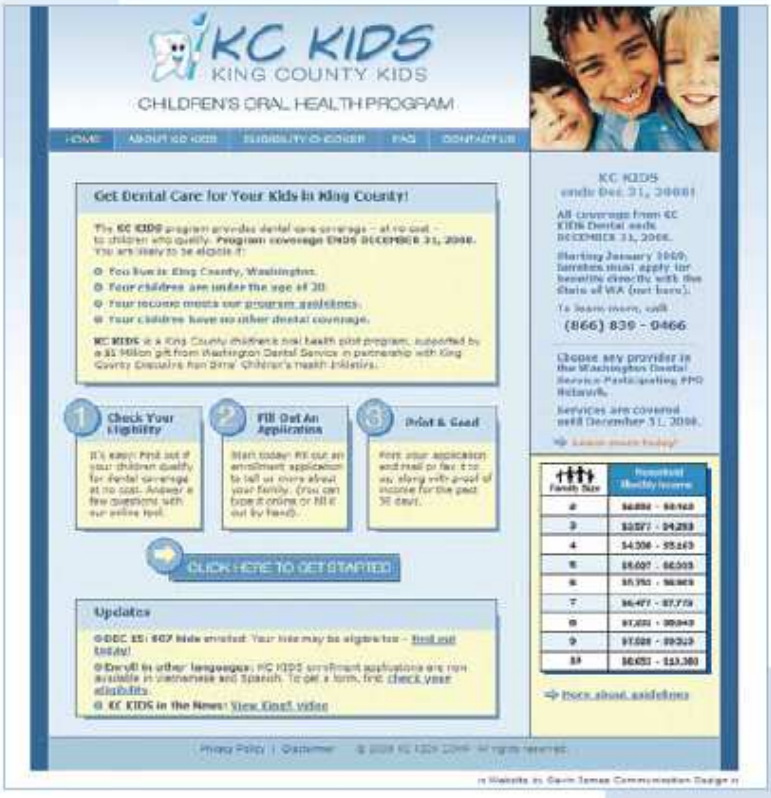
  When visitors submitted their information, the website's back-end database would process the data and provide a response page that suggested whether or not they were likely to be eligible for the program. If likely eligible, visitors were provided with links to download enrollment applications in one of three languages (English, Spanish, and Vietnamese). If the system determined they were not eligible, the site provided contact information for learning about providing other state programs that provide health care coverage.

- Support customer service with answers to common questions — In order to streamline customer service efforts and avoid "bottlenecking" the phone lines with basic inquiries, the website also provided a detailed section of frequently asked questions (FAQ), for both families and participating dentists. The website delivered this feature with handy interactive bullets that allowed visitors to easily scan and access questions and answers, without being overwhelmed by too much information all at once.

- Provide reporting for enrollment follow-up and metrics for progress — The KC KIDS team also needed to be able to capture as much contact information and demographic data as possible so they could track community needs and outreach progress. Additionally, they needed the data to enable timely follow up with any families who had met the initial eligibility requirements but had not yet submitted an enrollment application. To support the team with these reporting needs, the website's Eligibility Checker tool was backed by a database that organized all submitted information into a sortable spreadsheet, accessible online any time. Data for specified date ranges could be downloaded as an Excel spreadsheet.

  Furthermore, as the KC KIDS team needed to be able to track progress for the website itself, the web hosting tools provided statistical analysis that captured a wide range of factors, such as the number of visits per month, top pages visited, and so on.

The following pages provide screenshots of the KC KIDS website. For more information about the website's reporting tool and 2008 statistics, see the later section: Tracking Progress.



KC KIDS Website - Home Page

KC KIDS Website - Eligibility Checker Tool

KC KIDS Website - FAQ

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KC KIDS
Managing Administration

Overview

When the KC KIDS team at Washington Dental Service (WDS) took on the responsibility of developing, marketing, and administering the KC KIDS dental coverage pilot program, they were guided by three important goals:

- Be a good role model for the State — As the 2008 pilot program, KC KIDS served as an important demonstration to the State of Washington in preparation for the state's expanded health insurance coverage in 2009. As such, it was critical to ensure that all aspects of this program's enrollment and administration were well organized and cost-effective. The team achieved this goal by leveraging expertise and proven models within WDS to manage the pilot with the same high standards as all other established insurance plans.
- Get as many kids as possible to a dentist, as fast as possible — It was key to ensure that the program really worked well for the community it was designed to serve, which meant that enrollment had to be easy to understand, fast, and efficient, The KC KIDS team, along with their third party administration partner, closely tracked all applications and customer service needs to ensure that every eligible family found a provider and got the care they needed.
- Provide incentive for PPO participating dentists — As KC KIDS enrollees were accessing dentists in the WDS PPO Provider Network, WDS knew it was important to ensure that the providers could count on reliable and efficient processing of claims and reimbursals, and at their standard contracted rates. To ensure a smooth process, WDS set up this pilot program to run like any other plan or group that they manage.

Managing Enrollment

To effectively manage administration for the KC KIDS program, the team developed the enrollee materials noted below. Examples of many of these items are provided in the following pages.

- Enrollment Form (in English, Spanish, and Vietnamese)
- Patient Program Card
- Enrollee Handbook and PPO Participating Provider Directory
- Eligibility Denial Letter
- Enrollee Reminder Letter (sent quarterly to motivate dental visits)
- End of Program Letter (sent November 2008) and WA State Enrollment Application to access services in 2009

The WDS/KC KIDS team also developed tools to measure results throughout the year. See the following section: *Tracking Progress*

Delivering Quality Customer Service

As part of ensuring smooth administration of the program, the team closely monitored customer service needs, providing a toll-free phone number that was supported from 6:00 a.m. to 6:00 p.m. Monday through Friday. Along with the team's outreach efforts at many community locations (see the earlier section: **Managing Promotion & Outreach**), their customer service contact with interested families uncovered many touching stories of struggle and concern over not being able to afford dental care. Residents in cities all across King County expressed gratitude for the state programs helping them get this much-needed care for their children.

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

ENROLLMENT APPLICATION

KC KIDS is a children's oral health pilot program providing dental care coverage, at no cost, to children who qualify. You are likely to be eligible if:

- ❑ You live in King County, Washington.
- ❑ Your children are under the age of 20.
- ❑ Your income meets certain guidelines.
- ❑ Your children have no other dental coverage.

Enroll Today! The KC KIDS program runs from January 1 to December 31, 2008. In January 2009, families will need to apply for benefits through the state of WA. KC KIDS is a King County program supported by a $1 Million gift from Washington Dental Service.

HOW TO ENROLL

Prepare Your Application	Please fill out this entire application. Print clearly and use a pen. Sign and date the application, include proof of income, and mail or fax all documents to the address/fax number on the form.
Contact Us	If you have questions about this application or the KC KIDS Children's Oral Health Program, call (866) 839 - 9466. **Hours: Monday - Friday, 6 AM to 6 PM**
Learn More	Visit our website: www.kckidsdental.org

INCOME ELIGIBILITY

Family Size	Household Total Monthly Income *
2	$2,852 - $3,423
3	$3,577 - $4,293
4	$4,308 - $5,163
5	$5,027 - $6,033
6	$5,752 - $6,903
7	$6,477 - $7,773
8	$7,202 - $8,643
9	$7,928 - $9,513
10	$8,653 - $10,383

*** Income Guidelines**

If your income is below these guidelines, contact Community Health Access Program (CHAP) to learn about other health care programs.

(206) 296 - 4841

www.whf.org/programs/chap.aspx

January 2008

KC KIDS
KING COUNTY KIDS

CHILDREN'S ORAL HEALTH PROGRAM
ENROLLMENT APPLICATION

GETTING STARTED

Do your children have dental insurance or state Medicaid?	❑ YES	❑ NO
Are you a King County resident?	❑ YES	❑ NO
Number of people in your immediate family:	_____	

ADULTS IN YOUR HOUSEHOLD

ADULT #1

First Name | Middle Initial | Last Name

ADULT #2

First Name | Middle Initial | Last Name

CONTACT INFORMATION

Street (Include apartment or lot numbers)

City | State

Zipcode | County

Home or Work Phone Number

Mobile Phone Number

E-mail Address

Mailing Address (If different from Home Address)
Street / P.O. Box (Include apartment or lot numbers)

City | State

Zipcode | County

CITIZENSHIP/HERITAGE (optional)

Citizenship Your status does not affect your child's eligibility in this program	❑ U.S. Citizen ❑ Lawful Permanent Resident (Green Card holder 5 years or more) ❑ Refugee/Asylee
Racial/Ethnic Heritage	❑ Caucasian/White ❑ Hispanic orLatino ❑ African American or Black ❑ Asian ❑ Native Hawaiian or Pacific Islander ❑ American Indian or Alaska Native ❑ Other_____
Primary Language	❑ English ❑ Spanish ❑ Vietnamese ❑ Other_____

CHILDREN IN YOUR HOUSEHOLD

CHILD #1

First Name | Middle Initial | Last Name

Date of Birth (Month, Day, Year)

CHILD #2

First Name | Middle Initial | Last Name

Date of Birth (Month, Day, Year)

CHILD #3

First Name | Middle Initial | Last Name

Date of Birth (Month, Day, Year)

CHILD #4

First Name | Middle Initial | Last Name

Date of Birth (Month, Day, Year)

CHILD #5

First Name | Middle Initial | Last Name

Date of Birth (Month, Day, Year)

CHILD #6

First Name | Middle Initial | Last Name

Date of Birth (Month, Day, Year)

Do any of these children have a dental emergency? ❑ YES ❑ NO

KC KIDS
KING COUNTY KIDS

CHILDREN'S ORAL HEALTH PROGRAM
ENROLLMENT APPLICATION

INCOME INFORMATION

WAGES AND OTHER INCOME (Include income from all sources - see list below. Attach additional pages, if needed.)

Adults	Are you employed?		Monthly Wages Income (after taxes)	Other Monthly Income
Adult #1	Yes	No	$_____ per month (tips included)	$_____ per month
Adult #2	Yes	No	$_____ per month (tips included)	$_____ per month

Types of Other Income:

- Unemployment Benefits
- RSDI (Social Security Benefits)
- SSI (Supplemental Security Income)
- Veteran's Benefits
- Retirement Benefits
- Worker's Compensation
- Disability Payments
- Alimony
- Child Support
- Tribal Per Capita Payments
- Interest/Dividends Income
- Etc. (Please specify): _____

INCOME VERIFICATION

You must provide proof of income for the past 30 days (such as copies of payroll stubs or unemployment checks, written statements from employers, etc.). Include that documentation with your enrollment application. **Applications sent without proper documentation will not be accepted.**

ENROLLMENT AGREEMENT

I agree to the release of information from this application and supporting proof in order to evaluate and verify eligibility. I understand that Washington Dental Service (WDS) will maintain confidentiality according to the Health Insurance Portability and Accountability Act and any other applicable federal and state laws and regulations. This authorization is valid for 3 years from the date this application is signed.

I understand that this application is for one type of health benefit and is not applicable to any other medical services program.

I understand that children with KC KIDS Children's Oral Health Program will be eligible until December 31, 2008. I understand that I must apply through the state of Washington for any oral health programs beginning January 1, 2009.

SIGN AND DATE YOUR APPLICATION

I certify under penalty of perjury that the information on this application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away. I authorize Children's Oral Health Program to verify the information on this application.

_____ Signature

_____ Date

MAIL OR FAX YOUR APPLICATION (include documents for proof of income)

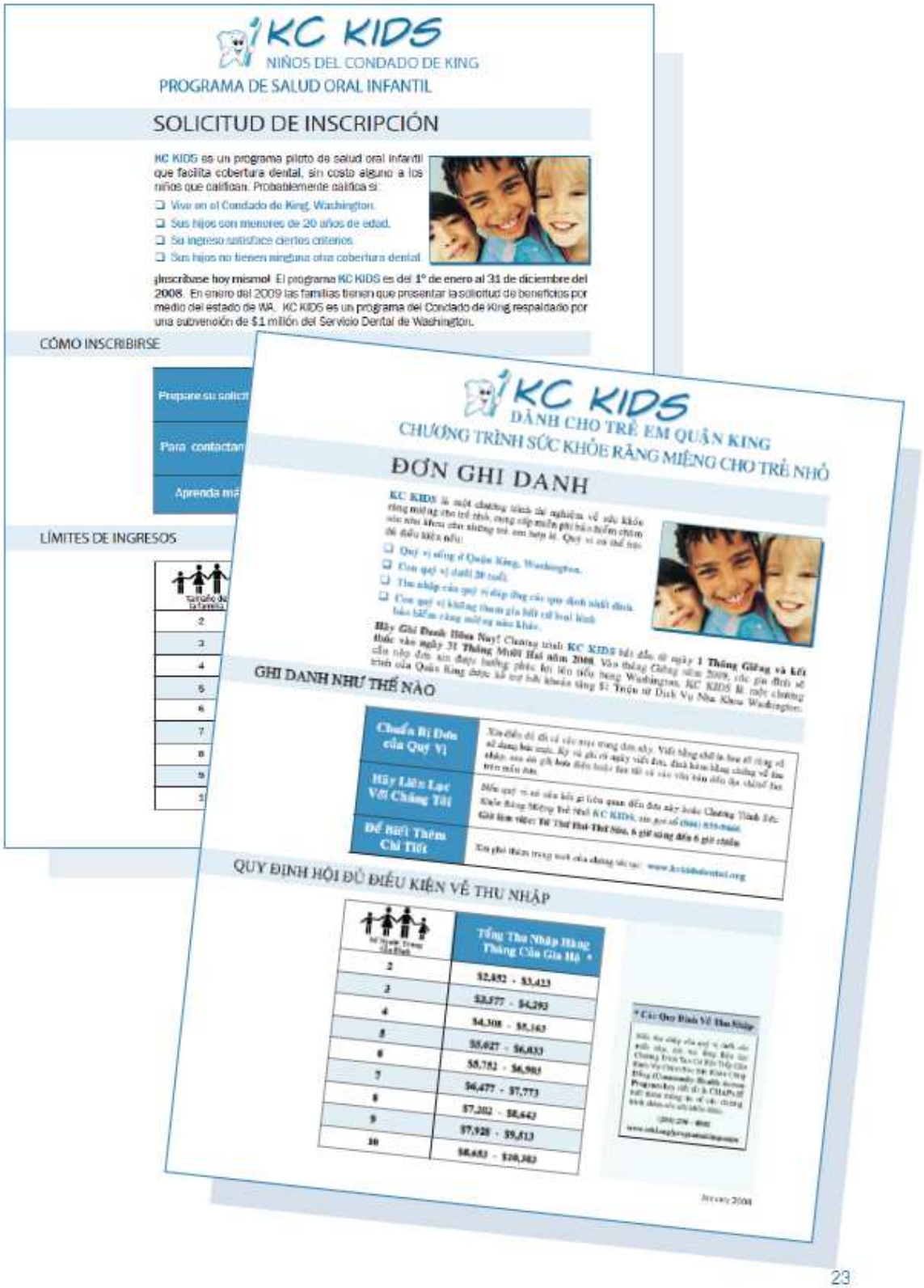
KC KIDS COHP
P.O. Box 75025
Seattle, WA 98175-0025

FAX NUMBER:
(206) 528 - 7391

How did you learn about KC KIDS?

❑ School ❑ Family or Friend
❑ Daycare ❑ Radio
❑ Employer ❑ TV ❑ Other_____

To learn about other health care programs, contact Community Health Access Program (CHAP) at (206) 296 - 4841 or visit their website: www.whf.org/programs/chap.aspx.



KC KIDS
NIÑOS DEL CONDADO DE KING
PROGRAMA DE SALUD ORAL INFANTIL

SOLICITUD DE INSCRIPCIÓN

KC KIDS es un programa piloto de salud oral infantil que facilita cobertura dental, sin costo alguno a los niños que califican. Probablemente califica si:

- ❑ Vive en el Condado de King, Washington.
- ❑ Sus hijos son menores de 20 años de edad.
- ❑ Su ingreso satisface ciertos criterios.
- ❑ Sus hijos no tienen ninguna otra cobertura dental.

¡Inscríbase hoy mismo! El programa KC KIDS es del 1° de enero al 31 de diciembre del 2008. En enero del 2009 las familias tienen que presentar la solicitud de beneficios por medio del estado de WA. KC KIDS es un programa del Condado de King respaldado por una subvención de $1 millón del Servicio Dental de Washington.

CÓMO INSCRIBIRSE

Prepare su solicit
Para contactar
Aprenda má

LÍMITES DE INGRESOS

KC KIDS
DÀNH CHO TRẺ EM QUẬN KING
CHƯƠNG TRÌNH SỨC KHỎE RĂNG MIỆNG CHO TRẺ NHỎ

ĐƠN GHI DANH

KC KIDS là một chương trình thí nghiệm về sức khỏe răng miệng cho trẻ nhỏ, cung cấp miễn phí bảo hiểm chăm sóc nha khoa cần thiết cho trẻ em hợp lệ. Quý vị có thể hợp lệ nếu:

- ❑ Quý vị sống ở Quận King, Washington.
- ❑ Con quý vị dưới 20 tuổi.
- ❑ Thu nhập của quý vị đáp ứng các quy định nhất định.
- ❑ Con quý vị không tham gia bất cứ loại bảo hiểm răng miệng nào khác.

Hãy Ghi Danh Hôm Nay! Chương trình KC KIDS bắt đầu từ ngày **1 Tháng Giêng và kết thúc vào ngày 31 Tháng Mười Hai năm 2008**. Vào tháng Giêng năm 2009, các gia đình sẽ cần nộp đơn xin được hưởng phúc lợi tiếp tục tại Washington. KC KIDS là một chương trình của Quận King được hỗ trợ bởi khoản tặng $1 Triệu từ Dịch Vụ Nha Khoa Washington.

GHI DANH NHƯ THẾ NÀO

Chuẩn Bị Đơn của Quý Vị	Xin điền đủ tất cả các mục trong đơn này. Viết bằng chữ in hoa rõ ràng và sử dụng bút mực. Ký và ghi rõ ngày viết đơn. Đính kèm bằng chứng về thu nhập sau khi gỡ hoặc điều hoàn tất cả các yêu cầu điền đủ chính xác trên mẫu đơn.
Hãy Liên Lạc Với Chúng Tôi	Nếu quý vị có câu hỏi gì liên quan đến đơn này hoặc Chương Trình Sức Khỏe Răng Miệng Trẻ Nhỏ KC KIDS, xin gọi số (206) 615-0660. Giờ làm việc: Từ Thứ Hai-Thứ Sáu, 8 giờ sáng đến 6 giờ chiều
Để Biết Thêm Chi Tiết	Xin ghé thăm trang web của chương trình tại: www.kckidsdental.org

QUY ĐỊNH HỘI ĐỦ ĐIỀU KIỆN VỀ THU NHẬP

Số Người Trong Gia Đình	Tổng Thu Nhập Hàng Tháng Của Gia Đình *
2	$2,852 - $3,423
3	$3,577 - $4,293
4	$4,308 - $5,163
5	$5,027 - $6,033
6	$5,752 - $6,903
7	$6,477 - $7,773
8	$7,202 - $8,642
9	$7,928 - $9,513
10	$8,653 - $10,383

* Các Quy Định Về Thu Nhập

January 2008

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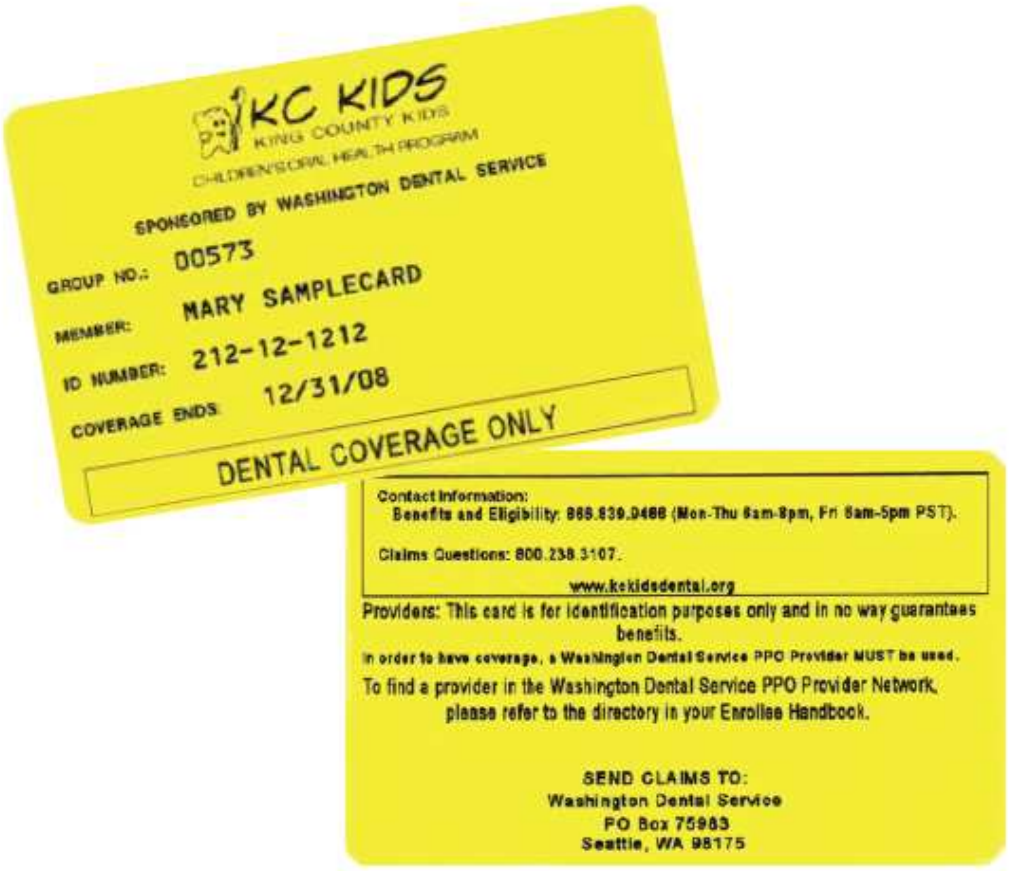

KC KIDS Children's Oral Health Program - Patient Card

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KC KIDS
KING COUNTY KIDS

CHILDREN'S ORAL HEALTH PROGRAM

HANDBOOK

JANUARY 2008

Table of Contents

Questions/Help

If you have questions about the **KC KIDS Dental** program, call our Customer Service department at (866) 839-9466.

Tell us that your question is about the KC KIDS Dental program and be ready to tell us your name, the child's name, the identification number from the child's Washington Dental Service Card, and your daytime phone number.

You can also find information about this program on the KC KIDS website: **www.kckidsdental.org**.

Welcome...

to KC KIDS Dental for King County, WA

This handbook tells you about the dental services covered by the **KC KIDS Dental** program for King County, Washington and how to use the plan.

Good dental health is an important part of your good health. The purpose of **KC KIDS Dental** is to help children and young adults get the dental care they need. We are glad you are part of this program, and we hope you will go to a dentist soon!

To receive the no-cost services of the **KC KIDS Dental** program, children must go to a Participating PPO Dentist within the Washington Dental Service network. Your enrollment packet includes a Dentist Directory of Participating PPO Dentists in your area. This plan does not cover treatment if you choose a dentist who is not a Participating PPO Dentist with Washington Dental Service.

The **KC KIDS Dental** program runs from January 1, 2008 to December 31, 2008. In January 2009, families will need to re-apply for benefits through the state of Washington.

We at Washington Dental Service want to support your good health and look forward to providing your **KC KIDS Dental** program.

❶ Definitions

❑ **KC KIDS Dental**

A dental program for eligible people under age 20 who live in King County, WA and have no other dental coverage.

❑ **Washington Dental Service**

The service provider for **KC KIDS Dental**. Washington Dental Service is sometimes referred to as **WDS**.

❑ **Beneficiary**

A person under age 20 who is enrolled in the **KC KIDS Dental** program.

❑ **Washington Dental Service Card**

A permanent (not monthly) card sent to each Beneficiary. Use this card whenever you see the Dentist. If you lose the card, call our Customer Service number at (866) 839-9466.

❑ **Participating PPO Dentist**
(KC KIDS Dental Dentist)

A contracted Dentist with Washington Dental Service. You may go to any WDS Participating PPO Dentist. WDS does not pay for any services from a non-participating PPO Dentist. To verify if your dentist is a Participating PPO Dentist, call our Customer Service number at (866) 839-9466.

❑ **Dentist Directory**

A list of Dentists who are Participating PPO Dentists with Washington Dental Service.

❑ **Handbook**

This booklet, for people enrolled in **KC KIDS Dental**. The Handbook tells you about plan benefits and how to use the plan.

❷ How to Use KC KIDS Dental

Follow these steps:

① Read your Handbook carefully to learn how **KC KIDS Dental** works and what is covered.

② Make an appointment with a Dentist listed in the **KC KIDS Dental Dentist Directory** (in Section 7 of this handbook). Tell the Dentist the Beneficiary is covered by Washington Dental Service and ask if he/she is a Participating PPO Dentist. (It's important to check on this because services are *not covered* if you go to a non-participating PPO Dentist.)

③ Be on time for your appointments, or call ahead if you must cancel. WDS does not pay for missed or broken appointments.

④ Show your Washington Dental Service Card at each appointment.

⑤ After treatment, your Dentist sends a claim form to Washington Dental Service. To help them, tell the dental office staff:

- ❑ Beneficiary's full name and address.
- ❑ Beneficiary's identification number on the card.
- ❑ Beneficiary's date of birth.
- ❑ The group name (**KC KIDS Dental**) and group number (00573).

⑥ If your Dentist has any questions about **KC KIDS Dental**, ask him or her to call Customer Service at (866) 839-9466.

⑦ Washington Dental Service will send you an Explanation of Benefits (EOB) that shows how much WDS paid. You must go to a Participating PPO Dentist or you will have to pay for your dental services.

❸ What KC KIDS Dental Covers

- ☑ Oral exams (2 in 12 months)
- ☑ X-rays
  - ❑ Bitewing X-rays (1 in 12 months)
  - ❑ Full mouth or panoramic X-rays (1 in 5 years)
  - ❑ Other X-rays as needed
- ☑ Teeth cleaning (2 in 12 months)
- ☑ Fluoride treatment (2 in 12 months under age 16)
- ☑ Sealant (1st permanent molars under age 9, 2nd permanent molars under age 14)
- ☑ Space maintainers (1 per space under age 14)
- ☑ Filling of cavities
- ☑ Resin crown (laboratory or prefabricated)
- ☑ Stainless steel crown (prefabricated)
- ☑ Sedative filling
- ☑ Crown buildup, including pins
- ☑ Root canals
- ☑ Extractions, simple and surgical
- ☑ Limited other oral surgery
- ☑ Emergency treatment of dental pain
- ☑ I.V. sedation (when medically necessary)
- ☑ Complete denture (1 time)
- ☑ Partial denture (1 time)
- ☑ Denture adjustments and repairs
- ☑ Denture rebase and reline (1 time)
- ☑ Temporary partial denture (only to replace front teeth)
- ☑ Re-cement crowns, bridges, space maintainers

Services Not Covered

The following services are NOT covered and you must pay for them:

- ☒ Bite guards
- ☒ Removal of healthy third molars (wisdom teeth)
- ☒ Bridges, inlays and crowns (except for resin/stainless steel crowns)
- ☒ Braces
- ☒ Implants
- ☒ Cosmetic dentistry
- ☒ Services covered under a hospital, surgical/medical or prescription drug program
- ☒ Treatment of TMJ (temporomandibular joint) disorder

❹ Questions & Answers

May I choose any Dentist?

You may choose any dentist in the Washington Dental Service PPO Provider Network. Although we prepare the Participating PPO Dentist Directory with our most current information, when you make an appointment ask the dentist if they are a Participating PPO Dentist with Washington Dental Service.

When does dental coverage begin?

When you qualify for the program, within a week you will be mailed a Washington Dental Service card. You are covered on the **KC KIDS Dental** plan until December 31, 2008.

Do I have to pay for dental services?

As long as your child goes to a WDS Participating PPO Dentist, you do not have to pay for services that Washington Dental Service covers. If you want a service that is not covered, you must pay for that service.

Does KC KIDS Dental cover all dental services?

No. The dental services covered are described in Section 3 of this Handbook.

What should I do in case of a dental emergency?

Call our customer service number (866) 839-9466 for a temporary enrollment card. If the emergency is life threatening, call 911 or the phone number for emergency medical services in your area.

What if I have questions about claims?

If you have questions about a claim, call our Customer Service **claims department** at (800) 238-3107.

What if my child needs specialty dental care?

Talk to your regular dentist about getting specialty care. If they refer you to a specialist, be sure he or she is a Participating PPO Dentist with Washington Dental Service. If not, you must pay for those speciality services.

❺ General Conditions

The following general rules apply to **KC KIDS Dental**:

Information and Dental Records

While you are covered by **KC KIDS Dental**, you agree to give us any information we need to process your claims. This includes letting Washington Dental Service have access to the Beneficiary's dental records.

Dentist-Patient Relationship

You may choose any Participating PPO Dentist within the Washington Dental Service network. He or she is solely responsible to you for dental advice and treatment and any resulting liability.

❻ Termination of Coverage

Any child under age 20 that is enrolled in the **KC KIDS Dental** program will be covered until December 31, 2008. In January 2009, families will need to apply for benefits through the state of Washington.

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

Thank you for submitting your application to the KC Kids Dental Program. We regret to inform you that your child does not qualify for the KC Kids Dental Program, as your income falls below the qualifying income guidelines for this program.

To see if you qualify for other health care programs, please contact Community Health Access Program (CHAP) at 206-296-4841 or visit their website at www.whf.org/programs/chap.aspx.

Thank You,
KC Kids Dental Program

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

Thank you for enrolling your children in the KC Kids Dental Program. We are excited to be involved in helping the children of King County receive oral health care in 2008. This is a reminder that this program is only for this year and will be over on December 31, 2008!!

If you have not taken your child to a dentist, we would like to encourage you to do so, as time is running out to receive services. Please take advantage of this great program and make a dental appointment today with a PPO Provider with Washington Dental Service.

Thank You,
KC Kids Dental Program

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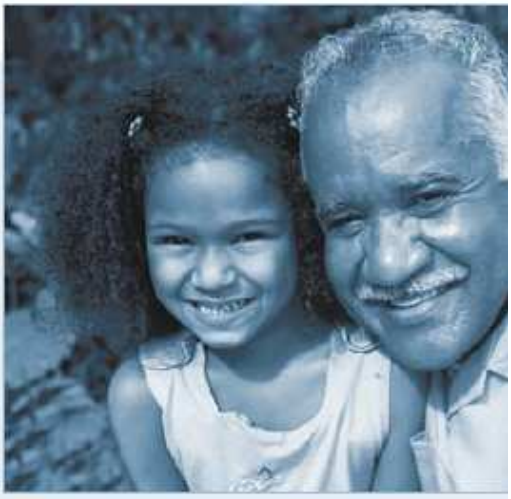
KC KIDS Customer Service Highlights

- KC KIDS Customer Service talked with the mother of an 18 year old boy who, long ago, had been diagnosed with needing a molar root canal, but his mother could not afford it. Later, when the boy's pain got so bad, she took her son back to the dentist, who recommended the tooth be pulled and referred her to an oral surgeon. She was able to pay for the consultation with the oral surgeon but could not afford all of the money up front for the extraction, so they postponed the surgery. By the time this family enrolled with the KC KIDS dental program, a year had passed and the boy now had pain up into the top of his head. The KC KIDS team helped them enroll and they immediately went in for treatment.

> *"I've received a good deal of positive feedback from my groups regarding the pilot program. For example, the HIHIT, a restaurant and hospitality trust has many workers who fit this demographic perfectly, and Amazon.com has many warehouse workers who will be able to take advantage of the program."*
>
> —WDS Account Coordinator

- Helped a 10 year old boy, whose mother could not afford dental treatment, yet said her son was in pain all the time. None of his baby teeth had fallen out, and he had two rows of teeth. With the KC KIDS program, the child was able to see a dentist to remove all of his baby teeth.
- A Public Health worker informed us about a 13 year old girl who was covered by Basic Health but had no dental coverage. She was in horrible pain but her family could not afford the root canal she needed. The KC KIDS team enrolled the girl on an emergency basis to get her into a specialist immediately.
- Customer Service helped an 18 year old girl who had been going to a community health clinic on a waived and reduced basis. She had 12 cavities and was told that she may lose a couple of her teeth due to bad decay before the clinic could get her in to fix them, as they could only schedule her for one hour at a time no matter what the need. The KC KIDS team enrolled her so she could get all of her cavities fixed and preserve her teeth.
- A school referred us to a 15 year old boy who was in severe pain. He had been advised by a Bellevue dentist that he needed multiple root canals and crowns; however, his family could not afford treatment. They had medical coupons, but the boy's father could not find a dentist who would accept them for payment. The family was underqualified for the KC KIDS program, however, given the circumstances, the KC KIDS team recommended emergency protocol for enrollment to help the boy get treatment.



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KC KIDS
Tracking Progress

Overview

As part of managing the KC KIDS dental pilot program, the KC KIDS team at Washington Dental Service (WDS) was responsible for tracking progress all throughout the program's one year run during 2008. They monitored statistics to evaluate the effectiveness and impact of the program from outreach and enrollment to provider access and the types of dental services being used.

- Enrollment Statistics — Leveraging the data gathered through the KC KIDS website reporting tool, as well as data captured throughout the enrollment process, the team tracked demographic details to help identify how well the program was working and where it was having the greatest impact. For example, March and April 2008 saw the highest enrollment numbers, likely boosted by the King5 news story that ran on television in March; and the cities with the greatest number of enrollees were Seattle, Renton, and Kent.
- Access Statistics — Throughout managing the claims process, the team tracked the number of children accessing PPO dentists, the number of different providers being seen, and the number of dental visits over the year.
- Website Statistics — The team also tracked activity on the KC KIDS website, reviewing the monthly traffic and frequency of use of the site's Eligibility Checker tool.

The KC KIDS dental program discovered a promising trend in seeing that 64% of the services delivered were preventive in nature, with only 36% of children requiring restorative services.

Results are detailed in the following pages, along with screenshots of the team's tracking tools.

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KC KIDS
Enrollment Statistics

Total Children Enrolled

808

January	54
February	77
March	89
April	115
May	78
June	82
July	42
August	56
September	71
October	83
November	45
December	16
TOTAL:	808

How Families Heard About KC KIDS

School	191
Family/Friend	49
Radio	48
Childcare	13
TV	11
Employer	7
Other	94

Other sources:

Poster, Public Health, Internet, NW News.com, DSHS, at work, library, church, dental office, pediatrician, letter in the mail, newspaper insert, YMCA, Kids Now Program, community center, Child Care Resources, Renton food bank, Salvation Army, Renton Parks & Recreation, Renton City News.

[Does not represent all enrollees]

Top 10 King County Cities for Enrolled Families

Seattle	120
Renton	44
Kent	38
Bellevue	27
Auburn	24
Federal Way	22
Kirkland	18
Burien	12
Maple Valley	11
Sammamish	9

[Represents a family application; often more than one child per application.]

Under-Income Families Referred to CHI Outreach Team

977

KC KIDS
Access Statistics

Total Enrollees Who Accessed Services

83%

Number of PPO Dentists Accessed

739

Month 2008	# of Dental Visits	Preventive Services Delivered	Restorative Services Delivered	Cost of Preventive Services	Cost of Restorative Services	Total Cost of Services
January	10	10	6	$1,971	$1,901	$3,872
February	22	20	12	$3,605	$8,669	$12,274
March	47	35	20	$6,614	$13,451	$20,065
April	77	66	28	$11,037	$10,433	$21,470
May	110	87	35	$16,613	$27,409	$44,022
June	75	40	35	$12,601	$23,320	$35,921
July	88	52	36	$14,462	$34,531	$48,993
August	131	86	42	$14,799	$36,631	$51,430
September	169	103	66	$18,062	$42,318	$60,380
October	143	111	66	$16,885	$57,648	$74,534
November	233	155	78	$26,310	$43,781	$70,091
December	199	146	97	$25,741	$68,663	$94,404
TOTALS:	**1,304**	**911**	**521**	**$168,701**	**$368,755**	**$537,456**

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KC KIDS
Website Statistics

Total 2008 Visits to the Website

17,082

Month 2008	Total Visits	Average Visits Per Day
January	40	1
February	1,352	46
March	2,060	66
April	2,122	70
May	2,194	70
June	1,521	50
July	1,447	46
August	1,487	47
September	1,668	55
October	1,284	41
November	1,038	34
December	869	28
TOTALS:	**17,082**	**52**

Total Hits on Eligibility Checker

2,774

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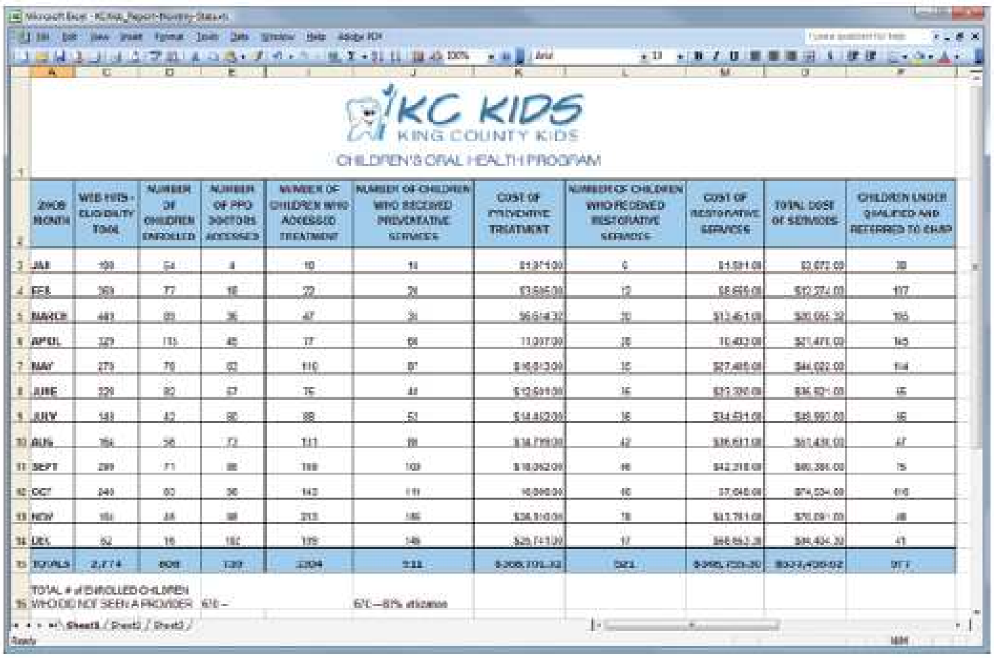
KC KIDS Tracking Tools



KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

2008 MONTH	WEB HITS - ELIGIBILITY TOOL	NUMBER OF CHILDREN ENROLLED	NUMBER OF PPO DOCTORS ACCESSED	NUMBER OF CHILDREN WHO ACCESSED TREATMENT	NUMBER OF CHILDREN WHO RECEIVED PREVENTATIVE SERVICES	COST OF PREVENTIVE TREATMENT	NUMBER OF CHILDREN WHO RECEIVED RESTORATIVE SERVICES	COST OF RESTORATIVE SERVICES	TOTAL COST OF SERVICES	CHILDREN UNDER QUALIFIED AND REFERRED TO CHIP
JAN	199	54	4	10	14	$1,971.00	6	$1,591.00	$3,072.00	30
FEB	369	77	18	22	28	$3,585.00	12	$8,685.00	$12,274.00	117
MARCH	483	89	36	47	31	$6,614.32	30	$13,451.00	$20,065.32	105
APRIL	329	115	45	77	68	11,007.00	38	10,403.00	$21,471.00	145
MAY	273	79	63	110	87	$16,613.00	35	$27,405.00	$44,022.00	114
JUNE	229	80	57	75	44	$12,601.00	16	$23,200.00	$36,521.00	65
JULY	143	42	80	88	53	$14,462.00	18	$34,531.00	$48,993.00	56
AUG	164	56	72	111	88	$14,799.00	42	$36,631.00	$51,430.00	47
SEPT	289	71	88	198	103	$18,062.00	46	$42,318.00	$60,380.00	75
OCT	240	60	36	142	111	16,990.00	46	37,646.00	$74,534.00	116
NOV	151	28	98	213	186	$26,310.00	78	$43,781.00	$70,091.00	28
DEC	62	16	182	179	148	$25,741.00	17	$68,663.38	$94,404.38	41
TOTALS	2,774	808	139	1304	511	$208,701.32	521	$365,735.30	$572,436.62	977

TOTAL # of ENROLLED CHILDREN WHO DID NOT SEEN A PROVIDER 670 – 670—87% utilization

Tracking Worksheet: Enrollment and Services Access

Website Eligibility Checker Reporting Tool [Password Protected]

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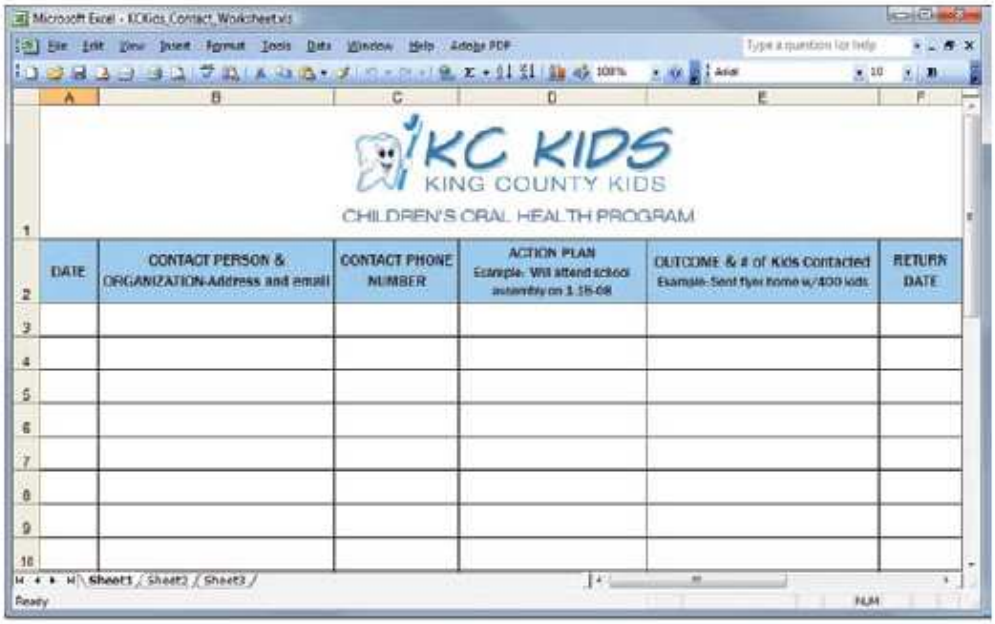
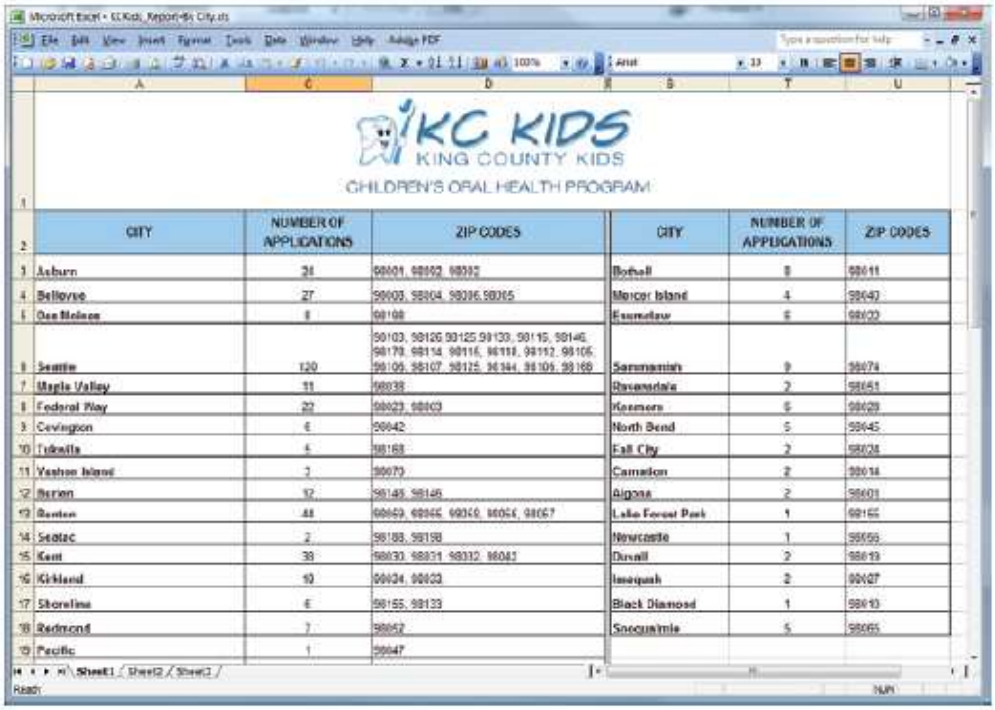


KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

DATE	CONTACT PERSON & ORGANIZATION-Address and email	CONTACT PHONE NUMBER	ACTION PLAN Example: Will attend school assembly on 1-15-08	OUTCOME & # of Kids Contacted Example: Sent flyer home w/400 kids	RETURN DATE

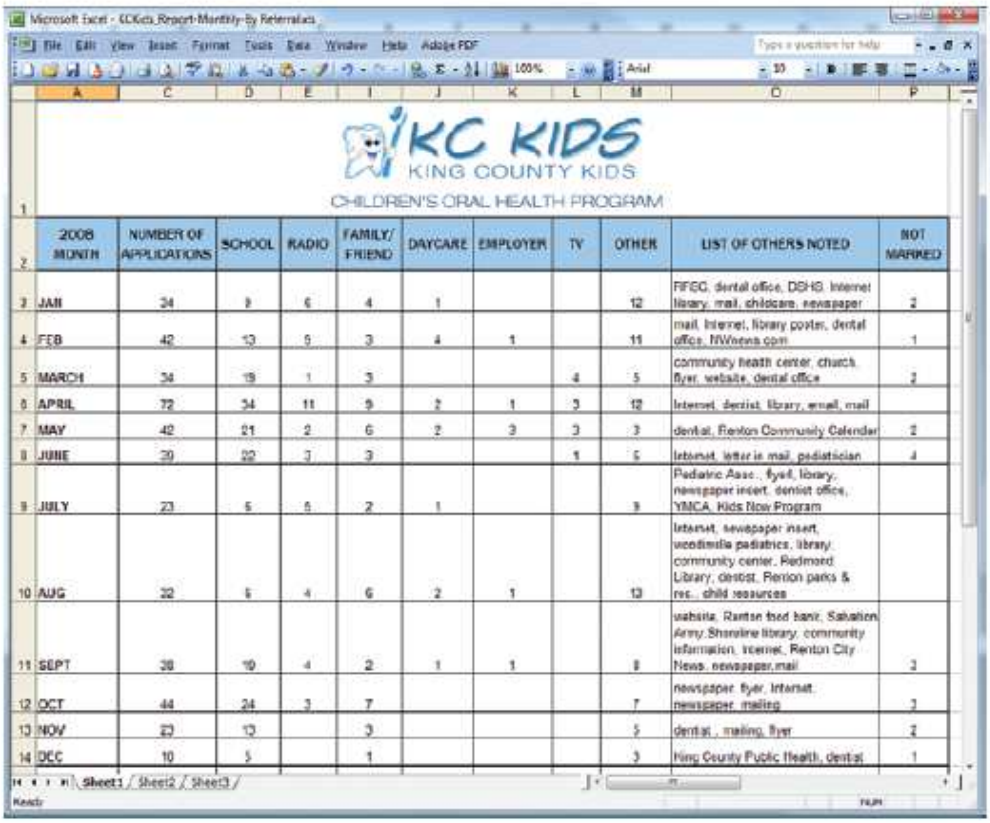
Tracking Worksheet: Outreach Activities



KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

CITY	NUMBER OF APPLICATIONS	ZIP CODES	CITY	NUMBER OF APPLICATIONS	ZIP CODES
Auburn	26	98001, 98002, 98092	Bothell	8	98011
Bellevue	27	98003, 98004, 98039,98005	Mercer Island	4	98040
Des Moines	8	98198	Enumclaw	6	98022
Seattle	120	98103, 98126,98125,98133, 98115, 98146, 98178, 98114, 98116, 98188, 98102, 98106, 98106, 98107, 98125, 98144, 98109, 98168	Sammamish	9	98074
Maple Valley	11	98038	Ravensdale	2	98051
Federal Way	22	98023, 98003	Kenmore	6	98028
Covington	6	98042	North Bend	5	98045
Tukwila	4	98168	Fall City	2	98024
Vashon Island	1	98070	Carnation	2	98014
Burien	12	98148, 98146	Algona	2	98001
Renton	48	98059, 98055, 98056, 98057	Lake Forest Park	1	98155
Seatac	2	98188, 98198	Newcastle	1	98059
Kent	38	98030, 98031, 98032, 98042	Duvall	2	98019
Kirkland	10	98034, 98033	Issaquah	2	98027
Shoreline	6	98155, 98133	Black Diamond	1	98010
Redmond	7	98052	Snoqualmie	5	98065
Pacific	1	98047			

Tracking Worksheet: Monthly Enrollment by City



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CHILDREN'S ORAL HEALTH PROGRAM

2008 MONTH	NUMBER OF APPLICATIONS	SCHOOL	RADIO	FAMILY/ FRIEND	DAYCARE	EMPLOYER	TV	OTHER	LIST OF OTHERS NOTED	NOT MARKED
JAN	34	9	6	4	1			12	FIFSC, dental office, DSHS, Internet library, mail, childcare, newspaper	2
FEB	42	13	5	3	4	1		11	mail, Internet, library poster, dental office, NWnews.com	1
MARCH	34	19	1	3			4	5	community health center, church, flyer, website, dental office	2
APRIL	72	34	11	9	2	1	3	12	Internet, dentist, library, email, mail	
MAY	42	21	2	6	2	3	3	3	dentist, Renton Community Calendar	2
JUNE	39	22	3	3			1	5	Internet, letter in mail, pediatrician	4
JULY	23	5	5	2	1			9	Pediatric Assc., flyer, library, newspaper insert, dentist office, YMCA, Kids Now Program	
AUG	32	5	4	6	2	1		13	Internet, newspaper insert, woodinville pediatrics, library, community center, Redmond Library, dentist, Renton parks & rec., child resources	
SEPT	38	19	4	2	1	1		8	website, Renton food bank, Salvation Army, Shoreline library, community information, Internet, Renton City News, newspaper,mail	3
OCT	44	24	3	7				7	newspaper, flyer, Internet, newspaper, mailing	3
NOV	23	13		3				5	dentist , mailing, flyer	2
DEC	10	5		1				3	King County Public Health, dentist	1

Tracking Worksheet: Monthly Enrollment by Referral Source

KC KIDS
Gathering Feedback

Overview

As a final part of managing and evaluating the success of the KC KIDS dental pilot program, the KC KIDS team at Washington Dental Service (WDS) distributed customer satisfaction surveys to both families of enrolled children and to participating dentists:

- Patient Survey — The patient survey polled satisfaction with issues from ease of enrollment and finding a dentist to the quality of care they received. The survey also encouraged families to offer their comments. Feedback was overwhelmingly enthusiastic, with parents expressing relief and gratitude for the help that the KC KIDS program brought to their children.

Nearly 100% of participating families surveyed were satisfied with the ease of enrollment and the dental services their kids received.

- Provider Survey — The provider survey primarily asked participating practitioners to evaluate administrative issues such as ease of processing claims and working with KC KIDS customer service. Similar to the parents' responses, many providers praised the program and expressed a strong desire to see such programs continue to be available, enabling them to provide services for more needy families.

92% of providers surveyed were satisfied with the overall program, and 89% were pleased with the efficiency of the claims process.

A Win-Win Success

Overall, the surveys showed that the KC KIDS dental program was a great success for both patients and providers. Each side shared much enthusiastic praise for the program and how it helped children who otherwise might not have been able to get the dental care they need.

A copy of each survey and the Results Summary Report are provided in the following pages.

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

KC KIDS Customer Satisfaction Survey Results

Throughout 2008, the KC KIDS Dental Program, sponsored by King County in partnership with Washington Dental Service, has been providing no-cost dental services for eligible families in King County, Washington. To measure the progress and success of the program, surveys were distributed to both patients and dental care providers who participated in KC KIDS. This report provides a summary of the survey results.

Patient Survey

Overwhelmingly, parents of children who received dental treatment expressed great enthusiasm, satisfaction, and gratitude for the program, with many requesting that it be continued in 2009. Their responses emphasize the very real need in our community, where many concerned parents cannot afford dental care for their children.

Number of surveys distributed: 305
Number of responses: 85 (28%)

Questions	Results
Ease of enrolling in the program	86% very satisfied 14% satisfied
Ease of finding a dentist	81% very satisfied 15% satisfied 3% neutral
Ability to get an appointment within 3 weeks of calling the office	73% very satisfied 18% satisfied 8% neutral 1% dissatisfied
Dentist's ability to treat your child's dental needs	78% very satisfied 21% satisfied 1% neutral
Quality of care and attention received at the dentist office	75% very satisfied 23% satisfied 2% neutral
KC KIDS Customer Service	76% very satisfied 15% satisfied 4% neutral 5% N/A

Other Comment Highlights

"This program has been an unbelievable help to us!"

"Amazing and vital program! I hope it is available after 2008!"

"This is an excellent program. I am very grateful. It would be wonderful if this program could continue."

"Loved it! This program is just what we needed. Dental care is expensive and easy to overlook."

"I was pleasantly amazed at how quickly, courteously and efficiently I was enrolled in this much needed program! My daughter had 2 cavities, which would have continued to go unnoticed until they caused a more serious problem if it hadn't been for KC Kids!"

"My 10 year old son needed 8 baby teeth pulled. This plan saved me! I don't know how I would have paid for his dental care. Thank you a million times!"

"Thank you so much for this program. I really hope it can continue. It has been a great help to my family; my 3 kids may not have had any dental care otherwise!"

"We have had a great experience in the care we received and cannot thank you enough!"

"I am so happy we found out about this program and qualified. We found it financially helpful and of great relief for our children's dentistry needs."

"This is a wonderful, well organized program. Please keep it for a long time or forever. Great service!"

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

KC KIDS Customer Satisfaction Survey Results

Provider Survey

For dental practitioners who provided services as part of the KC KIDS program, the majority were either very satisfied or satisfied, and many were enthusiastic to see it continue into 2009.

Number of surveys distributed: 165
Number of responses: 37 (22.4%)

Questions	Results
KC Kids Dental Plan (in general)	60% very satisfied 32% satisfied 8% neutral
Ease of verifying patient eligibility & benefits	48% very satisfied 41% satisfied 8% neutral 3% dissatisfied
Administration of KCKIDS Program compared to other dental plans	54% very satisfied 41% satisfied 5% neutral
KC KIDS Customer Service	51% very satisfied 35% satisfied 11% neutral 3% dissatisfied
Processing and payment of claims	54% very satisfied 35% satisfied 8% neutral 3% very dissatisfied
Patient compliance with office expectations and appointments	51% very satisfied 35% satisfied 14% neutral
How did you hear about it?	16 – patient inquiry 13 – WDS news 2 – TV/Radio Other: Another doctor; flyers; on their child's school parent-info website; Pediatric Study Group

"I love, love, love the fact that it is in cooperation with WDS. Excellent customer service - billings, questions, eligibility, etc. Such a pleasure to work with. A model for all insurances."

"I really hope someone donates this service for next year. It is a really good cause. All kids deserve a happy healthy smile."

"An awesome program... wish it could continue!"

"Excellent plan for children; excellent compensation."

"Should offer it for all, not only King County but Pierce County as well. Lots of families out there in need of some help."

"Patients saved a lot with this program. Thanks for thinking of all those kids without dental insurance."

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KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

WE APPRECIATE YOUR FEEDBACK!

Thank you for participating in the **KC KIDS Dental Program!** In partnership with King County and Washington Dental Service, we are pleased to be able to offer this special program to bring quality dental care to children in need during 2008.

To help us keep improving the program, we would appreciate your time in completing this brief survey. Please mail the completed survey to us using the self-addressed envelope or send it to the address below. If you have any questions, please contact us at (206) 528 - 7381.

KC KIDS SURVEY

For the following items, please rate your satisfaction with the KC KIDS Dental Program:

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
Ease of enrolling in the program	❑	❑	❑	❑	❑
Ease of finding a dentist	❑	❑	❑	❑	❑
Ability to get an appointment within 3 weeks of calling the office	❑	❑	❑	❑	❑
Dentist's ability to treat your child's dental needs	❑	❑	❑	❑	❑
Quality of care and attention you received at the dentist office	❑	❑	❑	❑	❑
KC KIDS Customer Service	❑	❑	❑	❑	❑

Comments _____

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CONTACT US

MAIL TO: KC KIDS COHP
P.O. Box 75025
Seattle, WA 98175-0025

PHONE: (206) 528 - 7381
FAX: (206) 528 - 7391

KC KIDS
KING COUNTY KIDS
CHILDREN'S ORAL HEALTH PROGRAM

WE APPRECIATE YOUR FEEDBACK!

Thank you for participating in the KC KIDS Dental Program! With the help of generous care providers like you, KC KIDS, in cooperation with King County and Washington Dental Service, has been very successful in bringing quality dental care to children in need during 2008.

To help us keep improving the program, we would appreciate your time in completing this brief survey. Please mail the completed survey to us using the self-addressed envelope or send it to the address below. If you have any questions, please contact us at (206) 528 - 7381.

KC KIDS SURVEY

How did you hear about the program? _____

For the following items, please rate your satisfaction with the KC KIDS Dental Program:

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
KC KIDS Dental Plan (in general)	❑	❑	❑	❑	❑
Ease of verifying patient eligibility and benefits	❑	❑	❑	❑	❑
Administration of KC KIDS Program compared to other dental plans	❑	❑	❑	❑	❑
KC KIDS Customer Service	❑	❑	❑	❑	❑
Processing and payment of claims	❑	❑	❑	❑	❑
Patient compliance with office expectations and appointments	❑	❑	❑	❑	❑

Comments _____

_____

_____

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KC KIDS
Acknowledgements

KC KIDS Program Management

Executive Sponsor:	Ron Inge, DDS, Vice President and Dental Director, Washington Dental Service
Project Manager:	Darlene O'Neill - Washington Dental Service
Outreach Workers:	Kristy Carstens and Catherine Fuller
Administration Support:	Mollie Roberts, Amanda Campbell - Employee Benefit Management Services
Marketing Communications & Website Development:	Gavin James Consulting - www.gjamesdesign.com

King County Partners

Ron Sims - King County Executive

Susan Johnson - Director, King County Health Action Plan

Susan Thompson - Health Program Analyst